

THE EFFECT OF SATIR BRIEF THERAPY ON PATIENTS IN A MATERNITY HOSPITAL

BY

BERTHA COHEN

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DECLARATION

I declare that “The Effect of Satir Brief therapy on Patients in a Maternity Hospital” is my own work and that all the sources that I have quoted have been indicated and acknowledged by means of complete references.

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Signature

B Cohen

.....

Date

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SUMMARY

As no known research has been done on Satir brief therapy in a maternity setting, an exploratory design using the case study method was used to assess whether women in a maternity hospital experience this form of therapy as beneficial.

Purposive sampling was used to obtain a sample of five patients for this study.

Therapeutic sessions were held with these women during their stay in hospital, and follow up sessions with four of the five women were held once they had been discharged home to evaluate their experience of the therapy. The fifth woman could not be reached after her discharge from hospital. The results indicate that the use of Satir brief therapy supports the research question and that it can therefore be used to address the psychological and social issues which can affect the mother baby dyad, thus promoting healthy mother - baby bonding.

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CHAPTER 1: THE RESEARCH PROBLEM

Introduction

In chapter one the following issues are presented: problem formulation, motivation for the study, aim and objectives, the research question, research design, context in which the research was conducted, limitations of the study, definition of terms and presentation of contents.

1.1 Problem formulation

Women with high risk pregnancies who come into a maternity hospital are often dealing with intense and complicated psychological, emotional and social issues. These seem to be manifesting more frequently. Among these issues may be domestic violence, chemical dependency, perinatal loss, medical issues for mom or babe, mental health issues or child protection concerns. (See appendix one for the breakdown of issues addressed by social work in British Columbia Women's Hospital) These issues can affect the ability of these mothers to bond with, and care for, their newborn babies.

The length of stay in hospital has become shorter: first time moms who deliver vaginally may stay for two nights, while women who have previously delivered a baby stay overnight. Women who have a caesarean section stay for three nights. This allows very little time for social work intervention to effect change in these women's lives should problems, as mentioned in paragraph one, manifest. It would therefore be important to

use the most effective type of brief therapy to address both the complexity of these women's issues as well as the extremely brief time span of hospitalization.

1.2 Motivation for the study

The brief therapies, i.e. behaviour therapy, cognitive therapy and solution focused therapy, described in the literature (see chapter two) focus on one dimension of change only, i.e. either on behaviour, or cognitions, with the assumption that a change in behaviour will impact on cognitions and feelings, and that a change in cognitions will affect behaviour and emotions. Satir brief therapy is the only brief therapy that includes working within all the dimensions of human experience, i.e. behaviour, cognitions, feelings, feelings about feelings, expectations, yearnings and spirituality. According to Banmen (1997), it is assumed that a change in one of these dimensions will bring about change in the other dimensions.

As every person is an individual with different needs, it is my opinion that it is more beneficial to offer a form of intervention that can be used to focus on more than one dimension if needed, in order to focus on individual needs and to offer the most possible benefit to women during their stay in hospital.

There is not a large body of research on Satir brief therapy, and to date no known research has been done on Satir brief therapy with women who have high risk pregnancies. It is for this reason that this exploratory study is being done, to find out whether women with high risk pregnancies in a maternity hospital experience Satir brief therapy as beneficial during the perinatal period.

1.3 Aim and objectives

The aim of the study is to assess the effectiveness of Satir brief therapy in a maternity setting which provides services to women with high risk pregnancies.

To achieve the above, the following objectives were set for the study:

- to effect first level change i.e. to create new awareness and find solutions to problems
- to effect second level change i.e. to transform feelings, perceptions, expectations and/or yearnings
- to effect third level change i.e. to effect change at the level of the self/soul.

1.4 The research question

What effect does Satir brief therapy have on patients in a maternity hospital?

1.5 Research design

1.5.1 Type of research design

The research design used in this study is the case study, an exploratory design. Grinnell (1985: 244-247) states that this is a hypothetical - developmental design, describing a single unit, i.e. an individual, over a specific period of time, to enable the researcher to develop ideas and hypotheses for further study.

1.5.2 Research method

The sources from which information was obtained include a review of the published literature on brief therapy, relevant documentation from patient's charts, therapeutic interviews with **four patients** while in hospital and follow up interviews with them at

home to explore their experience of the therapy, as well as discussions with members of the health care team, i.e. doctors and nurses in a maternity hospital providing services to women with high risk pregnancies.

1.5.3 The research process

A comprehensive literature study was conducted on brief therapy, including Satir brief therapy, and crisis intervention. Permission to do the research was obtained from the Research Review Committee of the Children's and Women's Health Centre of British Columbia (see appendix five), as well as from the Behavioural Research Ethics Board of the University of British Columbia (see appendix six). Researcher discussed the proposed study with the nursing program directors in the hospital, who then communicated this information to their nursing staff.

Social work referrals for the post partum wards were screened by researcher to ensure that they met the criteria for inclusion in the study, i.e., that the women were nineteen years of age and older, that they spoke English, that they lived in the greater Vancouver area and that they were not under the influence of drugs or alcohol. Researcher then discussed the nature of the study with each patient's nurse. Researcher asked the nurse to explain the study to his/her patient, and to inform researcher if the patient was interested in participating in the study.

Researcher went in to speak to the interested patients. The purpose of the research project was explained, with respondents being aware that the decision to participate in the research project was voluntary, and that social work intervention would be provided

whether or not they decided to participate in the study. A letter of consent was given to each patient who decided she wanted to participate (see appendix two). Once this letter had been signed, Satir brief therapy was provided at the woman's convenience.

Permission to use an audio recorder during interviews was obtained.

Therapeutic sessions using Satir brief therapy were held with these patients. Two sessions were held with the first patient. The first session lasted for one and a half hours and the second session was thirty minutes. One two hour session was provided to the second patient. Three sessions were held with the third patient. The first session lasted for half an hour; the second and third session each took an hour. The last therapeutic session of one hour which was provided (four previous sessions had been provided) to the fourth patient using Satir brief therapy was included in this study. Follow up interviews to evaluate the women's therapeutic experiences were held in their homes seven weeks after discharge from hospital.

The interviews were recorded and the data obtained was transcribed. The full interviews with the first client are presented in appendix four to provide an example of the kind of conversations the researcher had with the participants of the study. The data from the interviews with the participants was evaluated for themes and inferences were made in terms of Satir brief therapy.

1.5.4 Data collection method

The data collection method used in this study was the interview, which was used to provide Satir brief therapy. The interviews were audiotaped and then transcribed.

1.5.5 Sampling

The respondents were four post partum patients in a maternity hospital providing services to women with high risk pregnancies. Purposive sampling was used to obtain a sample of these patients. Grinnell (1985: 133) states that this type of sampling is used for the case study. There were certain criteria for women to be included in the study: women who spoke English; women who were nineteen years of age and older (nineteen years is the age of consent in Canada); women who lived in the greater Vancouver area; and women who were not under the influence of alcohol or drugs while in hospital.

1.6 The context in which the research was conducted

The research was conducted with patients in a maternity setting. B.C. Women's Hospital is a tertiary care centre which provides fetal, maternal and newborn care. It is a provincial and regional resource, integrating patient care, research and education. In addition to providing pregnant and post partum women with the necessary medical care and treatment, perinatal social work services are provided by the hospital to address psychological or social issues that may impact the safety of the mother and her baby, as well as mother infant bonding. These issues may be domestic violence, mental health issues, medical complications of mother or baby, relationship issues, child protection, perinatal loss or substance use. Most women come to B.C. Women's Hospital expecting to receive medical attention only. Initially they may not be aware of the perinatal social work services available to them.

1.7 Limitations of the study

As only four respondents were included in the study, it is not possible to generalize the findings to the larger population of women who receive social work intervention in a maternity hospital. It is also not possible to generalize the findings to women who do not speak English, to women who are younger than nineteen years of age, to women who do not live in the greater Vancouver area, and to women who may be under the influence of drugs or alcohol while in hospital.

Satir brief therapy is the identified independent variable. However, it is not known what part other unidentified variables played in the women's improvement.

1.8 Definitions of terms

B.C. Women's Hospital is short for British Columbia Women's Hospital.

Perinatal includes the time period of pregnancy, birth and the period after delivery.

Antenatal or antepartum indicates the time period during pregnancy before the baby is born.

Postnatal or postpartum denotes the time period after the baby has been born.

1.9 Presentation of contents

Chapter one presents an introduction to the research. Chapter two consists of a review of the literature on brief therapy, as well as on crisis intervention. Chapter three describes the model of Satir brief therapy. Chapters four and five respectively present the research design and the results of the research. Chapter six includes the conclusions and recommendations of the study.

CHAPTER 2: THEORETICAL AND LITERATURE STUDY

2. An overview of brief therapy and crisis intervention

Introduction

The history of brief therapy is discussed, as well as the definition and characteristics of brief therapy, client selection for brief therapy and the goals of brief therapy. In addition, different types of brief therapy are discussed, including solution focused brief therapy, behaviour therapy, cognitive therapy and single session therapy.

Crisis intervention is described and its characteristics discussed. The similarities and differences between solution focused therapy, behaviour modification and the cognitive therapies are discussed.

2.1 History of brief therapy

The origins of brief therapy can be traced back to the work of Milton Erickson.

De Shazer (1986: 207) states that Erickson published a paper in 1994 on the special techniques of brief hypnotherapy. In this paper he discussed “neurotic symptoms”, but made no attempt to attend to the underlying causes. According to Miller (1997: 37), Erickson assumed that clients had intelligence and skills, and he used their resources to help solve problems. De Shazer (1981: 234) states that “---- with an Ericksonian therapist there is no such thing as a problem, only something defined as somebody with a problem”. Erickson worked at creating conditions to persuade the client that he/she did not have a problem and communicated hopeful hypnotic messages.

Miller (1997: 37) states that members of the Mental Health Institute continued to develop and extend Erickson's work. They developed a systems approach to therapy, whereby problems were regarded as existing in clients' family relationships, instead of originating intrapsychically. This became known as family therapy and continued to develop in the late 1960's and early 1970's. Foley (1986: 138) maintains that in order for change to occur family members must relate in new ways. Once the pattern of family interaction changes individual family members change.

According to Foley (1986: 178), Minuchin, who developed structural family therapy, regarded a dysfunctional family as one in which communication patterns are distorted. In order for change to occur, the patterns of interaction are assessed and the role of the symptom that maintains the system is understood. The system can then be re-structured in order to function without the symptom.

Foley (1986: 182) states that in strategic family therapy problems are viewed as an indication of the system rather than the individual. Treatment is focused on the relief of the symptom with no reference made to its psychological meaning. Strategies such as paradox and double bind are used to force the system into new ways of behaving.

According to Foley (1986: 186), the Milan model is another type of strategic family therapy. It uses circular questioning to obtain information. A hypothesis is then formed of the family interaction which leads to a prescription for change.

In all the models of family therapy techniques were developed for disrupting problematic patterns and cycles within client family systems, and there was no longer an emphasis on diagnosing underlying pathology. According to De Shazer (1986: 208), it was also during this time that developments in brief therapy occurred, which dealt with problems, their maintenance and their solution.

Pardes and Pincus (in Budman 1981: 12) state that factors in the mental health field also played a part in focusing on briefer therapy. The classification for mental health disorders was advanced and there was an acceptance of more time limited goals, with an increasing awareness that long term treatment often did not meet the needs of certain groups of clients. The cost of therapy was a concern, as well as the need to increase access to treatment to all population groups. In addition, Spence (1983: 21) states that prepaid health plans were developed, which had limited mental health benefits.

Spence (1983: 21) perceived that the increased emphasis on therapeutic goals, the existence of less custodial care, and the development of group therapy resulted in the demand for more immediate results, and therefore briefer therapy. In extremely stressful situations there was also a need to deal immediately with the resultant psychological problems. Pardes and Pincus (in Budman 1981: 12) state that there was a development of varied therapies, as well as a coming together of therapies; for example, behaviour therapy now includes the cognitive aspect of perceptions, thoughts and beliefs.

2.2 Definition and some characteristics of brief therapy

Spence (1983: 3) defines brief therapy as having the “main common denominator (of) planned brevity.” Flexibility is used to structure the time and length of therapy and the

client is informed in advance of the number and length of sessions. Budman (1981: 46)

states that research and clinical findings have shown that the early sessions, i.e the first six

to eight, have the greatest impact.

Clients in brief therapy have often just experienced a crisis and prompt therapeutic intervention is based on rapid, early assessment. Focus is established early in the intervention. This central theme provides a sense of purpose and direction, enabling both client and therapist to gauge the degree of progress as therapy proceeds. Banmen (1997) states that brief therapy focuses on present coping skills, although the past may be reviewed so that present problems may be seen in context. There is recognition that change is inevitable, and individual strengths and possibilities for positive change are focused on.

According to Miller (1997: 27), brief therapists do not diagnose clients' problems, focusing instead on their perceptions of social reality. Problems are regarded as "inventions," and the focus is on developing short term solutions. Mann (in Budman 1981: 25) states that the emphasis is on clarifying the client's present emotional experiences, perceptions and behaviour.

Wilson (in Budman 1981: 159) maintains that the therapeutic relationship is of the utmost importance in brief therapy. Spence (1983: 52) states that there is pressure in brief therapy for the therapist to establish the therapeutic relationship quickly. According to Budman (1988: 27), brief therapy is collaborative and Walter and Peller (1992: 10) state

that the client is regarded as the expert. Banmen (1997) states that the therapist must work at creating a safe environment for client expression and experience.

According to Budman and Garman (in Budman 1988: 6), the therapist is very active in brief therapy, structuring the session, providing suggestions and asking leading questions. Spence (1983: 51) postulates that clients may experience intense emotions due to the directive and confrontational techniques of the therapy.

Budman (1988: 14) states that brief therapy identifies and builds on existing client strengths and skills. It is oriented to health rather than illness.

Miller (1997: 26 - 27) sees brief therapy as being characterized by “serious play.” Humour and optimism are used to counterbalance clients’ deficits and weaknesses, and problems are presented as a normal part of life and not a reason for losing hope. Brief therapists also “blur taken for granted cultural distinctions, including sanity and insanity, fact and fiction, and therapist-client roles.”

According to Satir, Banmen, Gerber and Gomori, (1991: 260-261), using a metaphor in therapy can hasten change. It is therefore suitable for use in brief therapy. The use of a metaphor creates a picture. This activates the senses and transmits an image to the brain, which results in perceptual changes. Satir et al (1991: 270) describe this: “a metaphor makes it possible to get a new sound and a new sight, a new touch, a new feel, and a new thought about something. That is what creates the change.”

Satir et al (1991: 158) state that when using a metaphor the right hemisphere of the brain is used. This avoids the circuits in the brain that resist change, and perceptual transformation occurs. This results in an increased awareness of new choices and possibilities.

According to Satir et al (1991: 262-273), using a metaphor creates distance between the client and the message, which reduces possible threat to the client. In addition, having a new perception can bring hope to the client, which can lead to change occurring very quickly.

According to Thompson (in Zeig and Gilligan 1990: 248), the use of myth and metaphors in brief therapy communicates effectively with the client at the level at which it is needed. Thompson (in Zeig and Gilligan 1990: 228) states that “The ambiguity and possibility of choice allows the patient to relate to what is needed by him rather than struggling to accept or reject an imposed framework.” The client is able to use his/her own frame of reference to interpret the metaphor. This can assist with the brevity of therapy, as the client is able to respond more quickly.

Metaphors can also trigger feelings and memories. Furthermore, metaphors can assist in accessing childhood behaviours for learning prior to the time when memories became imprinted with negative associations. Thompson (in Zeig and Gilligan 1990: 255) states: “Stories can be remembrances, projections, pure fantasy. They can be based on something the individual likes or doesn’t like, or they can merely be a simple statement.”

2.3 Selection of clients for brief therapy

Spence (1983: 6) describes the following client characteristics as being necessary for brief

therapy: good previous functioning; acute symptoms; the ability to relate; and receptiveness to the therapist. Motivation for change, recent onset of the problem, and ability to use communication in therapy are also regarded as important attributes for clients seeking brief therapy.

However, acute onset appears to be the most controversial and perhaps the least important, as Malan, who is cited by Spence (1983), provided evidence that this factor is not necessarily a good indicator. There have been several studies which have indicated that the severity of disturbance is one of the most important variables for predicting the success of therapy, whether short term therapy or long term therapy. According to Strupp (in Budman 1981: 224), when considering whether short term therapy is appropriate, person variables rather than “pathology” variables should be considered. An individual’s previous adjustment, ability to relate and motivation, constitute particular personality development organizations rather than certain symptoms or disorders.

Marmor (in Budman 1988: 2) postulates that clients with a clear focus, which is often crisis related, are often seen as ideal for brief therapy. In his opinion, there is a lack of empirical evidence to support the view that some people are more suitable for brief therapy than others. Marmor (in Budman 1988: 22) states that “Cited criteria do not discriminate between those who benefit differentially from short-term and long-term therapies, but may exclude those deemed least desirable by clinicians practicing this

modality.” He concludes that the best strategy is to assume that every client will be suitable for brief therapy unless proven otherwise.

Lazarus and Fay (in Zeig and Gilligan 1990: 41) state that it is important to use Prochaska and Di Clemente’s model of the stages of change to assess which stage a client is in when seeking brief therapy. They believe that clients in the pre-contemplative stage, when they have not yet started thinking about change, would not be suitable for brief therapy.

In Haley’s (in Zeig and Gilligan 1990: 13) opinion, there are clients with particular issues who would not be suitable to be treated in brief therapy. For instance, clients with chronic psychoses will need long term follow up. Also, when sexual or physical abuse has occurred and therapy has been legally mandated, monitoring will have to take place over time to ensure that no relapses occur.

Budman (1981: 23) feels that every individual, no matter what the diagnosis, will respond to brief therapy, unless proven otherwise. He cites McLean’s behavioural social skills program, Beck’s cognitive skills program and Klerman’s interpersonal therapy, all brief therapies, excluding only the most severely disturbed individuals, such as those suffering from organic brain syndromes, alcoholism or bipolar affective disorders, as evidence.

Budman (1988: 11) does not believe that there is a cure in therapy. He states that if a patient returns for therapy, often an assumption is made that there has been a relapse. He sees this as originating from Freud's belief that successful treatment means no further treatment should be required in the future. Budman (1988: 217) states that "---- the assumption should be made that patients can and do return for therapy at different points in their lives and that returning in this way is unrelated to the quality of the original therapy or its benefits to the patient."

Budman (1988: 24) questions whether an individual would benefit from brief, discontinuous treatments or whether it is necessary to have continuous long term therapy in order to change. He suggests that if a client has not responded to brief therapy, that brief therapy could be tried with a different therapist, a different type of brief therapy, a change of focus, change in length of sessions or time between sessions.

Assay and Lambert (in Hubble, Duncan and Miller 1999: 42-43) believe that brief therapy, from five to ten sessions, will benefit at least fifty percent of clients seen in regular clinical practice. In their opinion, the clients least likely to benefit are those who are hostile and unmotivated, who have a history of poor relationships and expect to be passive recipients in the therapeutic process. They advise that these clients should be identified early on in order to attempt to change their expectations and behaviour.

Assay and Lambert (in Hubble et al 1999: 42-43) state that studies have indicated that the benefits from brief therapy are lasting for most clients. They suggest that these benefits

can be retained by reinforcing the clients' belief that they have the ability to cope with setbacks which may be experienced after therapy has been completed. In order for clients to maintain the benefits gained during therapy, they believe that clients should be encouraged to perceive their gains as being a result of their own efforts, rather than due to the therapist or the therapy. Clients also need to be prepared for the possibility that they will experience problems in the future.

According to Assay and Lambert (in Hubble et al 1999: 42-43), the outcome of therapy is mainly determined by client variables and factors outside therapy, rather than by the therapist or the type of therapy provided. They cite Anderson and Lambert (1995) and Safran, Segal, Vallis, Shaw & Samstag (1993) and state that the results of various studies have shown that certain client characteristics consistently predict better outcomes of therapy, namely, the indices of the severity, chronicity and complexity of symptoms; client motivation, client coping style and the acceptance of responsibility for change.

Assay and Lambert (in Hubble et al 1999: 7-10) state that Lambert (1992) estimated that no matter what type of therapy was provided, that client factors account for forty percent of therapeutic improvement, the therapeutic relationship accounts for thirty percent of successful outcome and hope, and expected benefits account for fifteen percent of therapeutic benefit. The particular model or technique used accounts for fifteen percent of successful outcome.

2.4 Goals in brief therapy

Spence (1983: 4) maintains that the goal in brief therapy is not to reorganize the personality. De Shazer (in Zeig and Gilligan 1990: 98) states that the major difference between brief therapy and other therapies is that only a small and realistically achievable goal is necessary in brief therapy. According to Bergman (in Zeig and Gilligan 1990: 131), one of the reasons for having small goals is to ensure initial success for both client and therapist. This is particularly important, as one of the main reasons that clients seek treatment is that they have become demoralized over their previous inability to resolve their problems.

Goals, which are considered to be attainable in the brief time period, are chosen by both therapist and client. Budman (1988: 209) states that “Both clinical experience and research seem to confirm that a small change can lead to other changes, and, therefore, further improvement.” Inversely, it seems that the bigger the goal or the desired change, the harder it will be to establish a co-operative relationship, and the more likely that the client and therapist will fail. Goals should be measurable and they need to be frequently reviewed.

2.5 Types of brief therapy

2.5.1 Solution focused brief therapy

Miller (1997: 18) states that solution focused brief therapy regards clients’ problems as social constructions .i.e. problems are “literally talked into existence by clients and others in their social worlds and can therefore be talked out of existence if clients describe their

lives in new ways.” Rather than defining clients’ problems, the focus is on identifying solutions to these problems.

Walter and Peller (1992: 24) state that problems occur in the way people have defined situations and in their misdirected behaviour to solve these problems. They maintain that everyone has the ability to take a different course of action.

According to Walter and Peller (1992: 7-34), goals are well defined collaboratively in terms of what the client will be doing or thinking. The focus is on “solution talk” and not on “problem talk.” Thus the emphasis is either on what is already occurring, what has been resolved, or on exceptions to the problem. Clients will be asked to describe occurrences in their lives, families, relationships or marriages that they would like to continue to happen. In this way they are able to discern when their goal has been met.

O’Hanlon and Weiner-Davis (1989: 126) state that the aim is to identify the patterns of interaction round the problem, and then to interrupt this sequence. An expectation of change is thus created, which changes the client’s perception of the situation. Walter and Peller (1992: 64) assume that change is occurring all the time during therapy.

Follow up is based on client self report, although De Shazer (1986: 219) recognizes that there is a question of validity with this method. The findings indicated that solution focused therapy appeared to be effective within a short time period with a limited number of sessions. The rapid change also appeared to have lasting results.

2.5.2 Behaviour therapy

Behaviour therapy, or behaviour modification, is another type of brief therapy. According to Davison and Neale (1998: 518), this therapy attempts to change behaviour, thoughts and feelings. Schuyler (1991: 27) states that behaviour therapy emphasizes an initial analysis of behaviour in order to identify conditions of the behaviour to be changed. A baseline measurement of the behaviour is taken before therapy begins. Strategies from learning theory are used as interventions and when change occurs it is measured and documented.

Davison and Neale (1998: 518) distinguish between four different theoretical approaches in behaviour modification, namely, operant conditioning, counter conditioning, modeling and cognitive behaviour therapy. In operant conditioning, positive reinforcers and negative reinforcers are used to shape overt behaviour.

Counter conditioning is used to create new learning by eliciting a new response in the presence of a specific stimulus. Systematic desensitization is a type of counter conditioning and is used to reduce anxiety. In this procedure the client creates his/her fearful images while engaging in deep muscular relaxation. Aversion therapy is another type of counter conditioning in which stimuli are paired with negative stimuli to make them less attractive. This form of treatment can be used with heavy drinking, smoking, transvestism, exhibitionism and over eating.

Modeling is used in order for clients to learn complex behaviour. It eliminates emotional inhibitions by watching the desired behaviour in others.

.There is an emphasis on structured and applied theories of reinforcement. Self monitoring is encouraged and there is a focus on the attainment of goals. Wilson (in Budman 1981: 131) states that behaviour therapy is characteristically short term.

According to Schuyler (1991: 28), over the last decade there has been a convergence of behaviour and cognitive therapies. Cognitive therapy is described as another form of brief therapy, identifying cognitions which are relevant to the presenting problem and examining the evidence for and against key beliefs. The client is encouraged to try alternate cognitions and is taught to carry out the cognitive process independently. There is a focus on the client doing things in between sessions and homework assignments are given in which self monitoring is undertaken to record operationally defined perceptions, feelings or behaviour. Post session maintenance or booster sessions are available to the client.

Wilson in (Budman 1981: 132) states that social learning theory theorizes that environmental influences on behaviour are largely affected by cognitive processes, which are based on prior experience and affect. Which environmental influences are attended to, how they are seen, whether they will be remembered and how this will affect future functioning. Connections among thoughts, affect and behaviour are recognized. This

theory focuses on using behavioural procedures to change cognitive mediating processes, which in turn will affect the generalization and maintenance of behaviour change.

2.5.3 Cognitive therapy

Under this heading rational emotive therapy and Beck's theory of cognition is discussed.

2.5.4 Rational emotive therapy

According to Ellis (in Zeig and Gilligan 1990: 294), in order for clients to improve psychologically profound attitudinal change must occur. He developed rational emotive therapy, a form of cognitive therapy, so that patients could challenge the irrational beliefs which caused their disturbed feelings and behaviour.

Ellis is of the opinion that people's interpretation of external events can result in emotional

upheaval and that in therapy the focus should be on these irrational beliefs, instead of on the causes of the upheaval or on overt behaviour. He also states that people disturb themselves by holding on to dogmatic "shoulds" and "musts," and that they can use scientific questioning to challenge these irrational beliefs.

Ellis uses the technique of referenting, or refocusing, to get them to rethink their view of an issue. Reframing is a technique used to enable clients to see their situations differently, so that they are able to perceive the positive aspect. According to Ellis (in Zeig and Gilligan 1990: 297), "Thereby they can use several different kinds of reframing to effect a basic philosophical change about losses and frustrations."

According to Davison and Neale (1998: 528-529), once the therapist has become familiar with the client's problems, he/she will explain the theory of rational emotive behaviour therapy. When the client has been persuaded that his/her problems require rational examination, the client will be taught to substitute rational self-talk for irrational self-talk. When a client develops a different self statement during therapy, this must be incorporated into his/her thinking. Clients are given homework assignments so that they can experiment with these new self statements and experience the positive consequences of this. Ellis emphasizes the importance of helping a client to behave in a different way.

2.5.5 Beck's theory of cognition

Davison and Neale (1998: 47) state that Beck's theory of cognition focuses on how people distort their experiences, focusing only on negative occurrences. According to Davison and Neale (1998: 223), these negative experiences maintain what Beck has called "the negative triad: negative views of the self, the world and the future." The "world" part of this negative schemata refers to the individual's perception that he/she is unable to cope with external demands, rather than a concern regarding world events.

Beck has named several main cognitive biases of the depressed individual. Arbitrary inference occurs when conclusions are drawn without enough evidence, or without any evidence. Selective abstraction takes place when a conclusion is drawn on the basis of only one of many factors in a situation. Overgeneralization occurs when a conclusion is made on the basis of a single event. Magnification and minimization are exaggerations in the

evaluation of performance.

In Beck's theory, one's emotional reactions are considered to be a result of one's perceptions. Therapeutic attempts to change negative thinking are made at the behavioural

as well as at the cognitive level. Changes in thinking provide a basis for changes in behaviour. Davison and Neale (1998: 530) state that "The overall goal of Beck's cognitive therapy is to provide the client with experiences both in and outside the consulting room that will alter the negative schemata in a favorable way."

According to Davison and Neale (1998: 531), "collaborative empiricism" is inherent to Beck's therapy. Therapist and client work together to discover and examine any maladaptive interpretations of the world. They try to uncover both automatic thoughts and dysfunctional assumptions. The therapist assists the client to monitor the automatic thoughts and they will then jointly question their validity.

The therapist may persuade the client to change the dysfunctional assumptions and encourage behaviour which is not consistent with these assumptions. The client can then experience what happens when he/she does not behave according to these dysfunctional assumptions.

2.5.6 Single session therapy

Barber (in Zeig and Gilligan 1990: 441) cites Bloom (1981), who suggested several strategies to achieve success in a single session. He recommends that a focal problem is

identified and tentative interpretations offered, without paying too much attention to the event which precipitated the crisis. A problem solving process begins, while at the same time facilitating expression of emotions. He states that the therapist should play an active role, all the while being aware of the client's strengths. He emphasizes that it is important not to over estimate the client's self awareness i.e. "Don't ignore stating the obvious."

2.5.7 Crisis intervention

Myer (2001: 5) states that crisis intervention is "time limited treatment directed at reactions to a specific event in order to help the client return to a pre crisis level of functioning." Crisis intervention focuses only on a specific issue and assists in the resolution of that issue alone. If there are additional issues which need to be addressed, a change can be made and a more theoretical approach can be used, or a client can be referred for therapy. Crisis intervention is time limited, up to four weeks. The counselor and client can meet only once, or many times. They may meet for only a few minutes, or for several hours.

Budman (1981: 26) states that crisis counseling is provided with direct guidance, while appropriate community resources are accessed to restore psychological equilibrium. Parad

and Parad (undated: 47) describe the therapist as actively defining the goals throughout the process of crisis intervention. The goal of crisis intervention is to sustain the client's coping, allowing him/her to recuperate sufficiently to return to the previous level of functioning. Myer (2001: 7) states that the goal of crisis interventions is to integrate the experience of the crisis into the client's life by assisting in the development of

new coping skills, and/or adapting to the crisis.

Parad and Parad (undated: 51) state that crisis intervention is an action oriented approach. A directive, problem solving approach is often used, realistic and achievable goals are set and the assigning of tasks is clarified. Homework assignments are given, with an exploration of the reasons for success or failure in these tasks.

Myer (2001: 5) states that the goal of crisis intervention is not personality change or transformation, but is to re-establish immediate coping skills and to provide support. According to Parad and Parad (undated: 47), crisis intervention emphasizes the here and now, while brief therapy focuses on the past as it relates to the present crisis. They cite Marmor (1979), who states that crisis intervention and brief therapy are on a continuum, and that crisis intervention can overlap into brief therapy. Marmor describes the focus in brief dynamic therapy as changing the client's ability to cope and only secondarily relieving stress.

2.6 Similarities and differences between solution focused therapy, behaviour modification and the cognitive therapies

All these theories are based on the assumption that behaviour, thoughts and emotions are connected, and that a change in one aspect will lead to a change in another aspect. The difference lies in the focus of the dimension to be changed: the goal of behaviour modification is to change behaviour, which will then result in a change in cognitions and feelings; the goal of cognitive theory is to change beliefs, which will lead to emotional

and behavioural change; the goal of solution focused therapy is to work on a cognitive level to find solutions, which will then impact feelings and behaviour.

According to Davison and Neale (1998: 518), behaviour modification uses scientific techniques, which are based on the results of experiments, to effect change. In Davison and Neale's (1998: 530) opinion, Beck's theory of cognition has an empirical base, as both therapist and client work together to discover the client's maladaptive interpretations. However, they do not believe that Ellis's Rational Emotive Theory has a scientific basis, as they say that Ellis himself acknowledged that decisions about whether the client's beliefs are rational are based on what is regarded as functional or ethical rather than what is rational.

According to Walter and Peller (1992: 3-6), behaviour therapy focuses on the problem and how it was caused. Cognitive therapies also focus on identifying problematic perceptions and beliefs. However, instead of focusing on the problem, solution focused therapy focuses on finding solutions. The focus thus shifts from the past to the present and also anticipates the future.

Walter and Peller (1992: 10) state that solution focused therapy is a collaborative process, with the therapist and client working together to set the goals. The client is regarded as the expert. However, in behaviour therapy the therapist can be regarded as the expert, as he/she defines the problem and prescribes the treatment plan. According to Davison and Neale (1998: 532), Beck works collaboratively with clients, as the client's frame of

reference is taken into consideration. However, they regard the therapist in Rational Emotive Therapy as being didactic and confrontational.

Davison and Neale (1998: 547) state that a good client therapist relationship is important, no matter which form of therapy is used. This relationship requires that the client is able to trust and respect the therapist.

None of these brief therapies take into consideration the dimensions of feelings about feelings, expectations, yearnings or the spiritual aspect of human existence.

Summary

Crisis intervention has been discussed. Brief therapy has been described in order to gain an understanding and overview of this type of therapy. Certain types of brief therapy, such as behaviour therapy, solution focused therapy, cognitive therapy and single session therapy have been discussed in order to compare these types of brief therapies with one another. In chapter four the rationale for evaluating Satir brief therapy as opposed to crisis intervention or one of the above mentioned brief therapies is put forward.

CHAPTER 3: SATIR BRIEF THERAPY

Introduction

Satir brief therapy is discussed in detail. The components of this theory are described so that an understanding of the constructs and applications of this model can be gained. The characteristics and the spiritual aspects of Satir brief therapy are discussed, as well as the key concepts of congruence, self worth and self esteem, the stances, and the metaphor of the iceberg. Change and transformation in this model are described, as well as the use of this model in Chinese culture, and how it has been used with female survivors of sexual abuse. The rationale as to why this form of brief therapy should be researched and used with patients in a maternity hospital is put forward.

3.1 Characteristics of Satir brief therapy

Satir brief therapy is a growth model, unlike the previous brief therapies i.e. solution focused brief therapy, behaviour therapy and cognitive therapy, which have been discussed. According to Satir et al (1991:16), Satir brief therapy “is based on the human ability to change, expand, and manifest that growth.” Banmen (1997) maintains that every individual is unique and has inner resources and strength which is not being used. Satir et al (1991: 14) believe that every human being has the potential to realize his/her inner potential. Whatever issue the person is struggling with, change is possible. Every person has the necessary resources to change and grow, and change is possible for everyone, regardless of external events. Satir et al (1991: 27) state that “even if external

change is limited, change is also possible externally, i.e. in how we react to external events.”

Banmen in (Satir 1986: 491) describes Satir’s model as humanistic, as she believes people are able to change from coping at a basic survival level to becoming more fully human. She is of the opinion that these human processes are universal and occur in different situations and cultures.

Satir et al (1991: 6) believe that hope is a necessary ingredient for change to occur and believe that the focus should be on health and not on pathology. Andreas (1991: 9) says that instead of trying to remove problem behaviour, Satir asks what can take its place.

Satir assumes that everyone’s intentions are good, and that this therefore eliminates the concept of blame, focusing instead on desired outcomes. According to Woods (1984: 7), Satir regards the process of change as already having begun when an individual has made the decision to engage in therapy. She regards people with the most resistance as having the least hope and the greatest fear.

Woods (1984: 6) describes Satir as adapting her theory to the needs of the individual, rather than fitting the individual into her theoretical framework - “Her basic principles approach to theory ---therefore seems much more appropriate for the ultimate diversity seen in humans.” The therapeutic intervention is described as being a process which occurs between people and Woods states that “As a result of her flexibility, she is free to take almost as many risks in therapy as her clients must take.”

Satir regards mind and body as part of the same system, each affecting the other. She believes most people have either a preferred visual, auditory, or kinesthetic based representational system and she uses either the physical, intellectual, emotional, sensual, interactional, nutritional or spiritual levels of access when engaging in therapeutic contact with a client.

Woods (1984: 7) states that Satir believes that “self esteem and effective communication beget one another.” She also believes that the meaning of communication lies in the response it elicits, and not in its intention.

Woods (1984: 4) describes Satir as having a phenomenological approach, as she believes people are influenced by their perceptions and not by reality. In his opinion, she values wholeness, and sets store on individuals completing themselves in therapy.

Banmen (1997) states that Satir brief therapy is characterized by maintaining a clear focus, with conscious use of time. Set goals are formulated and the eclectic treatment techniques used are based on the client’s goals. The intervention concentrates on present copings – while the impact of the past is considered, change occurs in the present. Rapid initial assessment is used, which is integrated with treatment.

The therapist is very active, creating a safe environment for the client’s emotional

expression and experience. Woods (1984: 8) describes Satir's initial theoretical goal as that of creating an environment of "warmth, acceptance, respect, hope, and an orientation toward experimentation and change."

The overall theoretical goal is to facilitate change. Banmen (1997) states that the meta goal of therapy is for the client to become a better choice maker, to assume increased responsibility for the iceberg (metaphor for dimensions of human experience), to become more congruent and to increase his/her self esteem. The client may have goals at any/every level of the iceberg, and these goals need to be clarified.

3.2 The spiritual aspect of Satir brief therapy

Satir et al (1991: 14-19) believe that each person has an inner spiritual sacredness or spirit and manifests a universal life force. This life force is regarded as consisting of positive life energy, which is creative and growth inducing.

Lee (2002(b): 221) states that spirituality became increasingly important in Satir's work in the 1980's, when she described the third level of congruence as harmony with the self, life energy and spirituality/God. It appears that by the 1980's Satir regarded the spiritual aspect of therapy as being the most significant therapeutic tool in the process of transformation. Lee (2002(a): 61) quotes Satir: "I consider the first step in any change is to contact the spirit. Then together we can clear the way to release the energy for going towards health."

According to Lee (2002(a): 62), Satir describes growth as a “life force revealing itself--- of life coming from a power much greater than our own--- of our having a pipeline to universal intelligence and wisdom.” Lee describes Satir’s work as affirming and supporting the spirit. Satir uses meditations to assist people to access the right hemispheres of their brains and to come into contact with their intuitive selves, thus connecting with the universal spirit. Lee (2002(a): 62) quotes Satir: “Recognizing the power of spirit is what healing, living and spirituality are all about.”

3.3 Key concepts of Satir brief therapy

3.3.1 Congruence

Lee (2002(a): 63) defines congruence as “a state of awareness, acceptance and openness manifested as a harmonious flow of life energy through all levels and experiential dimensions of a person at a given moment.” Lee (2002(a): 64-65) describes congruence as the harmonious interaction between the intrapsychic, interpersonal and universal/spiritual aspects of a person.

In the 1950’s Satir regarded congruent communication as an unambiguous message. Lee (2002(b): 220) regards the first level of congruence in the Satir model as occurring at the interpersonal dimension, when the self, the other person and the context are recognized, acknowledged and accepted, so that there is no need to adopt a survival stance. Satir et al (1991: 65) describe congruence at this level as an ability to manage one’s feelings.

In the 1960’s Satir began to focus on the second level of congruence. According to Lee (2002(b): 221), this level of congruence occurs in the intrapsychic dimension, or the

iceberg, when internal experiences are recognized and acknowledged, and a decision is made to adopt new ways of being. Satir et al (1991: 68) describe this level of congruence as a state of centeredness and wholeness which focuses on the self/I am.

The third level of congruence focuses on spirituality and universality.

Lee (2002(b): 221-223) describes congruence at this level occurring when one's yearnings are acknowledged and accepted. In the 1980's Satir described congruence at this level as being in harmony with the self, one's essence, life energy or God.

All three levels of congruence are characterized by high self esteem. Congruence is a state of being that one moves towards, rather than a state that is achieved. When one is congruent one has the greatest access to one's inner resources. Lee (2002(a): 63) sums up congruence as "a bodily, holistic experience of energy flow that accompanies a systemic openness of the person in multiple dimensions."

An example of an individual who manifests congruence would be someone who is aware of, and accepts, his/her feelings and feelings about his/her feelings, has high self esteem and is able to honour both him/herself as well as the other person, is assertive and not reactive in social interactions, and experiences meaning and purpose in life with a sense of connection to the universal life energy.

3.3.2 Self worth and self esteem

Satir and Baldwin (1983: 3) describe self worth as the ideas and feelings an individual has about him/herself. Satir et al (1991: 17) believe that coping is an indication of the

level of one's self worth. In order to cope in a healthy way, one has to have a high level of self esteem. The higher one's self worth, the healthier the coping.

According to Innes (2002: 43), self esteem is the value one ascribes to oneself. Satir (1988: 21) states that self esteem can be positive or negative. "Because I own all of me, I can become intimately acquainted with me. By so doing, I can love me and be friendly with me in all my parts. I can then make it possible for all of me to work in my best interests." (Satir 1975: 28)

3.3.3 Stances

Satir et al (1991: 156) created four stances: the placator, the blamer, the super-reasonable and the irrelevant. Each stance represents coping patterns developed in childhood, to protect one's self worth against perceived threats to one's survival. Banmen (1986: 483) states that stances originate from low self esteem and are used to conceal weakness and avoid rejection. They are characterized by a particular body posture, gestures, sensations and syntax. The stances are incongruent as they either discount the self, the other person and/or the context.

According to Satir (1975: 71), each stance represents a universal and frequently occurring pattern of incongruity. Generally one stance is used when under stress, but more than one may be used.

Satir et al (1991: 2-3) describe the process of sculpting, which is used therapeutically to increase awareness of the unconscious. The physical posture depicting the

communication pattern of the stance that the client usually uses is adopted in therapy.

The inner experience of the physical sensations, feelings and perceptions is then processed, so that awareness is increased, and a decision can be made whether to move beyond the defenses to become more congruent. Banmen (1997) states that when it is known which stance a client uses, therapy time will be decreased.

3.3.3.1 Placator

Satir et al (1991: 36-40) describe the placating stance as one which discounts the self and honours the other person. Feelings of worthlessness are experienced, and anger is repressed and manifested in physical disorder, such as gastrointestinal problems.

The placator focuses on taking care of other people at the expense of his/her own needs, and assists them with solving their problems. This behaviour may be regarded as caring. An example of this stance is a woman with a medically high risk pregnancy who has been advised to go onto bed rest. However, she does not want her husband or children to have to manage on their own, so against medical advice she gets out of bed to cook and clean for them.

Psychological manifestations of this stance are depression or neurosis. The most extreme form of self sacrifice occurring in this stance can be seen in self destructive behaviour such as suicide. The physical posture symbolizing this stance is a person on his/her knees with one hand extended upwards and the other hand clasped over the heart. The placator may be reached therapeutically by exploring his/her feelings.

3.3.3.2 Blamer

According to Banmen (1997), the blamer discounts the other person and honours the self. He/she feels endangered by presumed verbal and non verbal threats and reacts by finding fault, judging, dictating and attacking. The blamer's behaviour can be explosive, and close relationships are often ended. This stance may be illustrated in a situation of domestic violence, when a man belittles and criticizes his partner, blames her for everything, attempts to control her behaviour and may be verbally and/or physically abusive towards her.

The psychological manifestations of this stance may be seen in delinquent, homicidal or paranoid behaviour. The most extreme form of this stance is manifested in violence. Satir et al (1991: 42) describe the physiological effects of this stance as circulatory problems and high blood pressure, muscle tension, back problems, arthritis or asthma.

The physical posture for this stance is symbolized by standing with an erect posture and a pointed, outstretched finger, with the other hand on the hip. According to Satir et al (1991: 41-44), this behaviour may be viewed as assertive, as the blamer stands up for him/herself. The blamer may be reached therapeutically by tapping into his/her expectations of other people.

3.3.3.3 Super-reasonable

Satir et al (1991: 45-48) describe the super reasonable stance as disregarding the self as well as the other person. The individual adopting this stance focuses on the context only, which usually consists of data and logic. Neither his/her own feelings, nor the feelings of

the other person, are considered. An example of this is a husband who accompanies his pregnant wife to hospital after they have learned that there is no fetal heart beat. His wife has been hospitalized and labour has been induced. His wife is trying to cope with her physical and emotional pain. However, after they have been informed of the medical details of their situation, he does not attend to her feelings or his own feelings, but works on his laptop computer.

This stance is characterized by rigid, obsessive behaviour. The person using this stance is often viewed as intelligent, but can be withdrawn and lonely. According to Banmen (1997), the super reasonable person may be reached therapeutically through his/her perceptions.

Satir et al (1991: 48) state that the psychological effects of this stance can be seen in obsessive-compulsive, sociopathic or catatonic behaviour. The physiological effects of this stance may manifest in heart attacks, cancer or mononucleosis. The posture for this stance is depicted by standing erect and stiff with an expressionless face, with the arms at the sides of the body.

3.3.3.4 Irrelevant

Banmen (1997) states that the irrelevant stance disregards his/her own needs, the need for other people and the context. The person using this stance continuously moves a part of his/her body and often displays inappropriate behaviour. This distracts from the subject being discussed, which is threatening to his/her self worth. Focus on any one subject is

not maintained. Therapeutic contact can be made through touch, participating in physical activity and discussing the context.

An illustration of this stance is a woman who is pregnant and is admitted to a maternity hospital for detoxification from drugs. When the social worker knocks on her door in order to discuss her situation, the woman steps out of the bathroom in the nude, and moves continuously round her room doing things, saying that it was a good time to have a discussion.

According to Satir et al (1991: 51-52), these individuals are often viewed as spontaneous and humorous. The physical posture for this stance is shown by standing, hunched, with the knees facing in and the arms and hands facing up and out. The head is to one side and parts of the face are twitching.

The psychological effects of this stance are confusion, inappropriate behaviour and psychosis. The physiological effects may be seen in a distressed nervous system, diabetes or migraines.

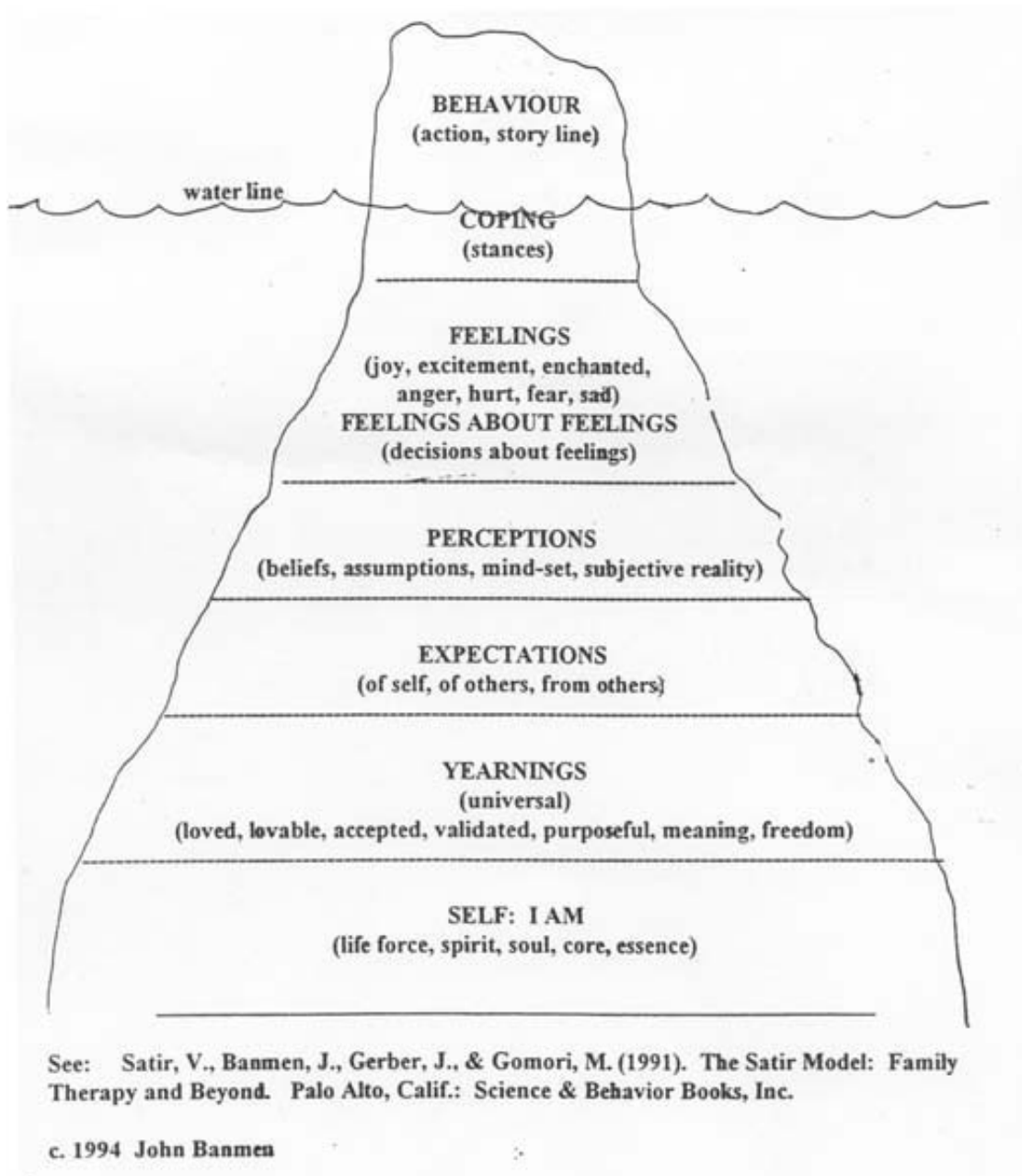
Satir et al (1991: 53) contend that “all communication stances contain seeds of wholeness. Placating harbours the seed of caring, blaming the seed of assertiveness, being super reasonable the seed of intelligence and being irrelevant the seed of creativity and flexibility.” As people using these stances are defending themselves, they are only using part of their abilities and are not realizing their full potential.

3.4 The iceberg metaphor

Satir uses the metaphor of the iceberg to graphically depict the different dimensions of human experience. The iceberg demonstrates that it is human behaviour and one's coping stances which are visible to other people, whereas the other dimensions of feelings, feelings about feelings, perceptions, expectations, yearnings and the self/I am are submerged and are experienced inwardly, not apparent to others, and are sometimes not clear either to the individual person.

The iceberg

THE PERSONAL ICEBERG METAPHOR OF THE SATIR MODEL



According to Banmen (2002(b): 7), the various levels of the iceberg constitute a system, and a change in one level can effect change in the other levels. Lee (2002(a): 66) states that the levels are interactive, and when they interact harmoniously, a state of congruence exists. Smith (2002: 24) believes that the components of the iceberg are universal, but manifest uniquely in each individual. Lee (2002(a): 64) describes the iceberg as having

interpersonal dimensions (behaviour and stances), intrapsychic dimensions (feelings, feelings about feelings, perceptions and expectations) and spiritual dimensions (yearnings and the self/Iam). Therapeutic intervention can occur at any level of the iceberg.

The various dimensions of the iceberg metaphor will now be discussed.

3.4.1 Behaviour

Satir et al (1991: 156) describe behaviour as “the external manifestation of our self esteem.” Banmen (2003) maintains that this dimension consists of the action that is seen by others. Changes occur in the actions taken as a result of changes in other levels of the iceberg. For example, when a man is depressed he is no longer able to behave in the same way as he did previously towards his wife. Initially she may think that he no longer loves her and may feel hurt and angry, as her expectations and yearnings are not being met. She may withdraw from him as a result of her inner experiences. However, once she is able to perceive that the reason for the change in his behaviour is that he is suffering from depression, she may no longer expect the same attention from him, nor feel hurt or angry, and may be able to behave in a loving and caring way towards him.

3.4.2 Feelings

Lum (2000: 20) defines feelings as an inner response experienced by everyone, even though conscious awareness of these feelings may not exist. Feelings can be an inner response to either internal or external stimulæ. Feelings can consist of happiness, sadness, excitement, hurt, fear and anger. Satir et al (1991: 155) describe the latter three

feelings as most likely to be reactive, based on feelings which have accumulated from one's family of origin in the past.

3.4.3 Feelings about feelings

Satir (1988: 45) states that feelings about feelings are an indication of self worth. A person with high self esteem is able to accept his/her feelings about his/her feelings, instead of judging them. According to Satir et al (1991: 158), transformation occurs when feelings are recognized and there is the realization that a choice exists as to what to do with them. Banmen (1997) states that when feelings are reactive, perceptions and expectations may have to be connected to these feelings before the client can let go of them.

3.4.4 Perceptions

Satir (1988: 44) describes perceptions as "Thoughts you have and the meaning you ascribe to them." They can be beliefs, attitudes, values, ideas, cognitions and assumptions. Lum (2000: 19) states that Satir believes people are motivated by their perceptions and not by the actual situation. Perceptions are formed from a limited knowledge base, and are incomplete interpretations, which should be expanded during therapy. Perceptions are strongly connected to our sense of self.

Transformation occurs when new information is added to perceptions, which can then impact feelings and expectations. According to Andreas (1991: 10), Satir uses reframing to change people's perceptions, so that they appear in a more positive light.

For example, a woman who is on welfare and has delivered a baby needs to stay on in hospital with her baby as the baby is jaundiced. She has called her financial worker at the welfare office to request that a cheque is made out for her so that when she and baby are discharged over the weekend she can buy some baby supplies. The worker has told her that before she can make out a cheque the woman needs to come in with her baby. The patient became involved in an argument with the worker and started crying over the phone. She demanded to speak to the worker's supervisor, and was told that a cheque would be ready for her at the end of the day. The patient relayed the story to the hospital social worker, feeling very defeated and asking why she had had to beg for her money. The social worker reframed her experience by pointing out that the patient had had the strength to be assertive, which had resulted in her being able to access the money that day, something that rarely occurred without the woman going in with her baby to see the financial worker.

Satir also uses metaphors to reframe perceptions, which is very powerful as it uses the right side of the brain. Metaphorical reframing occurs, for example, when a client feels overwhelmed by the issues still to be addressed, and does not experience that any progress has been made. The therapist points out that the client can liken the situation to his/her being in the process of climbing up a mountain and wanting to reach the top. The climb is arduous, and for some time all the client can see is the next step ahead to be navigated. However, if the client looks down, he/she can see how far up he/she has climbed, and thereby perceive the progress that has been made. In addition, if he/she

looks up, the summit can be glimpsed in the distance, engendering hope that it is in fact within reach.

3.4.5 Expectations

Satir regards expectations as originating from yearnings. There are the expectations we have of ourselves, the expectations we have of others, and the expectations others have of us. Banmen (1997) states that unmet expectations often result in reactive emotional behaviour.

In order for transformation to occur, clients need to be made aware of their expectations, and to take ownership of them. If the client decides to hold on to the expectation, the costs of this to the client is discussed. A decision needs to be made whether to let go of an expectation, in which case grieving, which must be processed, will occur. The client may find an alternative way of meeting the expectation, or may need to fill the yearning behind the expectation.

For example, when a couple experiences multiple pregnancy losses, the partners may decide to continue to try to have children, but need to be aware that further pregnancies may induce much anxiety, and if they suffer another loss they will experience further grieving. If they decide to let go of the hope of having children biologically, this will also be a loss, which will need to be grieved. The clients may decide to explore the possibility of adopting a child, which will fulfill their yearning to experience being parents. Or they

may decide to fulfill their yearnings by finding meaning in volunteering their time for an organization providing services to children.

3.4.6 Yearnings

Satir et al (1991: 151) regard human yearnings as the longing to be loved, love others and love oneself. Yearnings represent the need for acceptance, validation, purpose, meaning and freedom. Satir believes that human yearnings are universal. If one's yearnings have been fulfilled, high self esteem, congruence and healthy coping mechanisms develop. Morrison and Ferris (2002: 164) state that people then become responsible for their inner and outer worlds and become positive choice makers.

According to Lee (2002(a): 69), Satir believes that when an awareness of one's yearnings is increased, acknowledged and accepted, then this process connects one to our inner life force or self/I am.

3.4.7 The self/I am

According to Innes (2002: 44), Satir regards the self as a Mandala, an Eastern metaphor depicting wholeness. The Mandala represents the physical, mental, emotional, interactional, sensual, nutritional, contextual and spiritual aspects of a person. "Although each facet may be identified separately, it is the dynamic interplay of these elements that constitutes the whole self."

The self is very closely connected to people's universal yearnings. Morrison and Ferris (2002: 163) state that this inner core experiences peace and harmony when yearnings

have been met. Satir believes that the self affects behaviour, and the context affects the self, and that often these effects occur simultaneously.

Satir et al (1991: 148) describe the self as “the core.....the source of our inner experiences” which manifests a spiritual life energy. Satir et al (1991: 14) perceive people as having an inner sacredness or spirituality which manifests as a life force or positive life energy. According to Banmen (1997), the self is the life force, spirit, soul/essence of one’s being. Lum (2000: 15) describes the self is a place where there is a spiritual connection to the universal life force, providing a source of life energy for the individual.

3.5 Change and transformation in the Satir model

The main goal of the Satir model is to effect change. First level change occurs when therapeutic support is provided, awareness is increased and solutions are found to the client’s problems.

When change occurs within the dimensions of the iceberg, this is regarded as transformation, or second level change. According to Maki Banmen (2005), negative energy is then freed up and replaced with positive energy. Satir et al (1991: 149-163) maintain that each level of the iceberg needs exploration. Transformation is possible in each of these dimensions, which will then lead to an improvement in coping.

When the therapist taps into the client’s feelings, a change can often result in his/her expectations and perceptions. When a client is re experiencing feelings, these can be

acknowledged and accepted. If the therapist then increases the client's awareness of his/her perceptions and expectations and connects them to the feelings, the client is often able to let go of these feelings.

A change in expectations and perceptions can result in a change in the client's feelings about his/her feelings.

The therapist can tap into the level of perceptions and can add new information to correct previous interpretations and decisions. The resultant new perceptions can then change the individual's expectations and feelings.

When the client becomes aware of his/her unmet expectations during therapy, and is able to acknowledge them, he/she can let go of these expectations, or can develop expectations in accordance with his/her yearnings and the reality. Alternatively, the client can return to his/her yearnings and can find other ways to meet his/her yearnings.

During this process of transformation, by therapeutically increasing awareness by adding a new perception, feeling or expectation, a new coping pattern is established. Satir et al (1991: 144) state that clients can then "move from the automatic to the conscious level of response, giving themselves choices and new possibilities for change."

Banmen (2002(b): 21) views transformation within the Satir model as an intense experiential acceptance, which frees the individual from unfinished business. This

resultant change is then anchored, which “includes accepting the change, making room for change in the different parts of the internal process (the iceberg metaphor) and integrating the change.” Homework is given between sessions to practice the change. Internal change results in external change, which is manifested in an individual’s behaviour and interaction with the outside world.

According to Sayles (2002: 94-109), during transformation an individual’s inner resources are uncovered, and the self, not a past event, takes control. In the process of transformation, emotions which are acknowledged and experienced at a very deep level are stored in the brain and cells of the body as memories. These changes are received by nerve impulses which move across the cell membrane and produce changes in behaviour and mood. Sayles (2002: 109) describes transformation as “a situation in which a person experiences at the core of himself or herself, the possibility of being in charge of what is felt, believed, and experienced.”

When the therapist taps into the client’s yearnings, this increases awareness, which the client can then acknowledge and accept. This process connects the individual to his/her inner core or life force, the self/I am.

Satir believes transformation occurs when energy is changed from a dysfunctional pattern to a healthy pattern, so that it can flow unimpeded through the individual. Cheung et al (2002: 214) state that Satir believes that it is not the therapist who provides the healing, but the client, by unleashing the energy within - “The therapist is like someone carrying a

set of jumper cables. The client is there filled with energy, but the problem is, it is not working. The therapist moves in, and the energy starts flowing. It is the activation of energy that creates a movement of healing.”

Satir maintains that in order to become healthy, contact must be made with the universal energy which underlies existence, so that the different intrapsychic levels can be brought into harmony with this source. Satir et al (1991: 81) state: “When I can be in touch with another person’s spiritual energy and he/she with mine, there is a change in the state of consciousness.” Satir used meditations to assist people to connect with their own internal spirit as well as with the universal life force.

Banmen (1997) states that when contact is made with this universal life force, third level change occurs. Maki -Banmen (2005) describes third level change as occurring when a client chooses life over destructive behaviour which can result in death.

3.6 Use of this model in other cultures

It can be asked whether Satir brief therapy can be applied to people in other cultures.

Very little research has been done on this. Cheung and Chan (2002: 202)) have commented on the applicability of the use of Satir brief therapy in Chinese culture. They state that Satir brief therapy is based on the “egalitarian individualistic ethos” of the United States, where self fulfillment is the norm, identity is defined by achievement and individual qualities and free expression are upheld. In Hong Kong, by contrast, traditional Chinese culture values hierarchical collectivism, where collective welfare is a priority, personal identity is attached to one’s role, respect for authority, harmony and

order is expected and self restraint is valued. Cheung and Chan (2002: 206) state that “In this hierarchical collective context, any attempt to forcefully make a change from the hierarchical model to the growth model will be sheer imposition.”

Cheung and Chan (2002: 200) maintain that in order to facilitate change, the therapist must be sensitive to the client’s culture. In addition, for change to be lasting, it must be able to survive in the particular culture. The results of interviews with participants after attending workshops in Satir brief therapy in Hong Kong revealed that while some of the participants remembered achieving positive changes as a result of the therapy, they found the changes difficult to maintain once they were back with their families in another cultural context.

Cheung and Chan (2002: 210-211) found that when they practiced Satir brief therapy with clients with a traditional Chinese culture, these clients did not return to therapy. The focus on self made them feel that they were expected to discard the collective. With the focus on the individual self, they felt that they were asked to discard their ascribed roles, “their moral self and collective identity.” With the emphasis on self determination and equality, they felt they had to abandon their obligations to their parents and cause disharmony. The focus on independent and free expression was an indication to them that instead of traditionally avoiding conflict, they were expected to break family rules.

As has been discussed, Satir differentiated three levels of congruence. Cheung and Chan (2002: 208) maintain that change at level one occurs within the culture of egalitarian individualism. Here the emphasis is on the self, being honest with feelings, and on

choice, freedom and responsibility. They describe congruence at level two as congruent communication - while the focus is still on the self, it extends to others and the context. A new state of harmony then exists, with peace being experienced within, with others and with the context. At level three Satir encouraged a connection to the universal life force, when the existing energy is activated therapeutically, resulting in healing.

While level one is suppressed in Chinese culture, the values in levels two and three are similar. Cheung and Chan (2002: 211) state that in Chinese culture “It is in the act of affirming others that one affirms oneself.” They conclude that instead of beginning therapy at level one, it would be more effective to begin at level two when using Satir brief therapy in Chinese culture.

From Cheung and Chan’s findings it can be concluded that it is important to respect a client’s cultural background when applying Satir brief therapy.

3.7 The use of Satir brief therapy with female survivors of sexual abuse

Morrison and Ferris (2002: 165) used Satir brief therapy in group work with female survivors of childhood sexual abuse. People who are experiencing sexual abuse are seen as having a growing life force, fully capable of achieving internal harmony and congruence, rather than as victims of external pain that controls their lives. Therapy is focused on the impact of the abuse on the present behaviour and how the past has influenced them intrapsychically, as reflected in the metaphor of the iceberg. This metaphor is used to explore the impact of the abuse on each of the client’s internal dimensions, which will then shift.

Morrison and Ferris (2002: 168) conclude that clients emerge with a new internal freedom that allows them to live from an inner source of harmony and positive life energy. They will have transformed their inner sense of self by exploring the impact of the abuse without having to work much with the events. Morrisson and Ferris (2002: 168) state that “It appears that working with the impact of one’s life experience results in much more lasting internal changes than reworking the sharing of the story.”

In her work with Carol, a victim of sexual abuse, Morrison (in Morrisson and Ferris 2002: 178) describes how she focused on Carol’s positive potential, and that the client later stated how important that was in her healing, as it was the first time she had been told that she had potential. She became clear about her boundaries and her ability to set them. “Carol became able to see herself as a lovable, worthy person apart from her experiences and she was relieved to no longer define herself through her abuse. Carol became able to experience and release the intense anger towards her father, her mother, and her childhood family experiences. She transformed the anger’s negative energy into wishing that she had not had to experience the abuse, but accepting that this was a piece of her past. ----Carol was then able to find some inner peace.”

3.8 The rationale for evaluating the use of Satir brief therapy as opposed to crisis intervention or another type of brief therapy

As the goal of crisis intervention is to re-establish coping skills, and not to effect personality change or transformation, it is preferable to present women in a maternity hospital with the opportunity to change, so that there is the chance of reaching a higher level of functioning than existed prior to the crisis.

Being a growth model, Satir brief therapy provides hope for all clients, as it assumes that everyone has the necessary internal resources to grow and change, and that change is always possible, no matter what the external conditions. This model is also humanistic, assuming that people are able to actualize their potential and become more fully human.

Unlike the other types of brief therapy previously discussed, which work on changing either behaviour, cognitions or feelings, Satir brief therapy is able to address all these dimensions. It also includes the levels of expectations, yearnings and spirituality, and is thus able to address all aspects of human experience.

Attention to the dimension of yearnings is particularly suited to working with women during the perinatal period, as this may assist the mother- baby bonding process. It can also be very helpful with the issue of loss, as a woman may experience the loss of her baby, the loss of a relationship with the baby's father, the loss of having a healthy baby, the loss of her health, and may trigger other unresolved losses she has previously experienced.

The Satir model is also cognizant of the role of spirituality in the process of transformation. It is importance to be able to attend to this dimension when spirituality plays a part in a client's life.

Change at the level of yearnings and the self/I am brings about psychological transformation, which does not necessarily occur with the use of the other brief therapies previously discussed.

In addition to effecting change intrapsychically, Satir brief therapy addresses the interpersonal aspect of human experience by working with the stances. This is important as the women may be experiencing problems in their relationships with their partners or family members.

Considering the very short time period in which women are generally in hospital after delivering their babies, it is best to use a type of therapy which provides the most opportunity not only to effect change, but also to bring about transformation, within the shortest possible time. I believe that Satir brief therapy is the model most able to do this, and therefore consider that it is important to undertake research with the use of this model in a maternity hospital, so that its effectiveness within this context can be assessed.

Summary

As has been seen, most brief therapies work with only certain aspects of human experience, while Satir brief therapy addresses all aspects. It is for this reason that it has been decided to evaluate how women experience this type of brief therapy.

CHAPTER 4: RESEARCH DESIGN

Introduction

The way in which the research was undertaken is described. The reasons for using the particular type of design are given, the type of sampling and the characteristics of the sample are discussed, and the method of data collection is described.

4.1 Type of research design

The case study is the type of research design used in this study. Grinnell (1985: 244-247) states that this is a hypothetical-developmental design which describes a single unit, i.e. an individual, over a specific period of time. This is an appropriate design to use for this study, as according to Yin (1989: 13-25), the case study is used to answer explanatory questions, as in this study, what the effect of Satir brief therapy is on patients in a maternity hospital. In addition, this study, like the case study, is not able to control behavioural events, and the focus is on a contemporary event within its real - life context. This type of design also enables the researcher to develop ideas and hypotheses for further research.

4.2 Sampling design

The participants in the study originally consisted of five patients in a maternity hospital treating women with high risk pregnancies. One of these women could not be reached after she had been discharged from hospital, so the study has four participants. These women had social, emotional and/or psychological concerns which required social work intervention. Purposive sampling was used to obtain this sample of patients. Grinnell

(1985: 133) states that this type of sampling is used for case studies. The following exclusion criteria applied: women who do not speak English; women under nineteen years of age (the age of consent in Canada is nineteen years); women under the influence of alcohol or drugs while in hospital; women who do not live in the Lower Mainland (in the greater Vancouver area); and women with child protection issues.

4.3 Method of data collection

A literature search was done on brief therapy in general, particular kinds of brief therapy, crisis intervention and Satir brief therapy.

Researcher obtained permission to do the research study from the Research Review Committee of Children's and Women's Health Centre of British Columbia (see appendix five), and from the Behavioural Research Ethics Board of the University of British Columbia (see appendix six). Researcher then consulted with the nursing program directors of the antepartum wards, the birthing suite and the postpartum wards at B.C. Women's Hospital so that they were fully informed of the study and could thus inform their staff of the study.

The charts for new social work referrals for postpartum clients were assessed by the researcher (who in also one of the social workers for postpartum wards at the hospital) to ascertain that the women spoke English, that they were nineteen years of age or older, that there were no alcohol or drug issues, that there were no child protection issues and that they lived in the Lower Mainland. There were five women who met these criteria.

Researcher read their charts to obtain relevant medical, social and psychological information.

Researcher discussed the study with these women's nurses and requested that they inform the patients of the study to ascertain whether the women were willing to participate, on the understanding that their participation was entirely voluntary, and that they would still receive social work services even if they chose not to participate.

Once a nurse reported that a woman was willing to participate, researcher explained the purpose of the study to each woman and discussed any concerns or questions the patient had. Permission was obtained from the woman to use an audiotape during the sessions. A letter of consent (see appendix two) was left with each woman, so that she could read it and decide within twenty four hours whether she definitely wanted to participate.

When the woman had signed the letter of consent, researcher met again with her in case there were any other concerns that she wanted to discuss before counseling began.

Therapy was then provided at a time convenient for the women and was audiotaped.

Follow up interviews were held with four of the five women in their homes seven weeks after they had been discharged from hospital with their babies to evaluate their experience of the sessions in hospital. The fifth woman did not respond to telephone messages from researcher requesting that a date be set so that they could meet.

The data obtained from the audiotapes was transcribed and analyzed for the purpose of evaluating the women's experiences of the therapeutic sessions.

CHAPTER 5: RESULTS OF THE EMPIRICAL STUDY.

Introduction

A description of each client's situation and iceberg is given. An analysis of the social work intervention provided, using Satir brief therapy to address the presenting issues, is discussed. Problem solving and therapeutic support provided are described, as well as changes in the clients' icebergs during the therapeutic interventions. Each client's experience of the therapeutic intervention is discussed.

5.1 Carey^{*}

5.1.1 A description of Carey's situation

Carey is a 34 year old married woman with a daughter of seven years old. She had an unplanned pregnancy and delivered her baby son vaginally at 39 weeks gestation. She suffered a third degree tear during the labour.

A social work referral was made out as Carey had experienced a very difficult labour and was feeling very upset about this. She was willing to see a social worker to discuss this. The nurse who completed the referral was concerned as the family had immigrated to Canada during Carey's pregnancy and she felt that it was possible that the family was struggling financially, as Carey's husband had not yet obtained full time employment.

^{*} Fictitious Name.

During her pregnancy Carey attended a community antenatal program which provides support to pregnant women. She described herself as having been slightly depressed during her pregnancy.

Her brother lives in the downstairs suite of the home they rent. She has an aunt and uncle who are supportive, but live in another part of Canada. Although the couple has friends, they live at a distance from them and Carey regards herself as being isolated.

Researcher had two sessions with Carey during her stay in hospital. During the first session Carey and researcher were the only people present. During the second session Carey's husband arrived towards the end of the session when community resources were being discussed.

5.1.2 Carey's iceberg

5.1.2.1 Behaviour

Carey cried when describing her traumatic birthing experience. She cried when she questioned whether she and her husband had done the right thing by immigrating to Canada. She also cried when speaking about her mother's death. She was attentive to her baby throughout the sessions and provided appropriate baby care.

5.1.2.2 Stance

It appears that Carey may be super-reasonable, as she appeared to remain at the level of her perceptions and did not seem to access her feelings very easily. For example, when

discussing her family's immigration to Canada, she spoke of the advantages to her children of being in Canada, but did not acknowledge the impact that this move had on her emotionally.

5.1.2.3 Feelings

Initially Carey was unhappy about her unplanned pregnancy. She described herself as being slightly depressed during her pregnancy. She was fearful prior to her labour.

She had been surprised and very disappointed that her labour had been so difficult, and had experienced it as very overwhelming. However, she felt that she was less overwhelmed than she had been immediately after the delivery. She was shocked that she had delivered a boy and not a girl, but was very happy to have a son. She felt insecure as her husband had not been able to find permanent employment. She felt upset that her husband could not be with her continuously while she was in hospital, as he had to care for their young daughter at home.

5.1.2.4 Feelings about feelings

Carey felt "silly" because she cried so easily.

5.1.2.5 Perceptions

Carey decided to accept her unplanned pregnancy, as it would not be fair to her unborn child if it had to suffer because she did not want it. Carey perceived that she had suffered during her labour and questioned why she had to suffer so much, and why she was the only one on the labour ward at that time who had had such a difficult birthing experience.

After such an experience she did not want to become pregnant again and have to experience labour.

She was of the opinion that over time she would heal and that she would recover: “It will get better. I should be okay.” She thought that if she had coped through such a difficult experience during her labour, that it should not be too difficult to organize things so that she could cope at home.

She and her husband wanted to immigrate to Canada while they were still young, as they thought it would be more difficult when they were older. They saw a better future for their children in Canada. They felt that they had sacrificed much to come to Canada, but that it was worth it. Carey realized that the financial stress the family was under was causing conflict between her and her husband, and she questioned whether they had done the right thing by immigrating. She believes that her deceased mother exists in spirit and watches over the family.

5.1.2.6 Expectations

Carey’s pregnancy was unexpected. They had planned on having only one child. She had expected to deliver a girl.

She had expected a short labour, which was easier than the delivery of her first child. She experienced her labour as being unexpectedly difficult. However, she expected that with time that she would recover from the trauma of her delivery.

Carey expected to be busy at home with her new baby, and did not think that it would be easy. She experienced her family as having expectations that she would be there for them (“They all depend on me”).

She and her husband immigrated to Canada because they expected to have a better future. They had expected to find permanent employment without difficulty. Carey has an expectation that she should be able to buy a house for her children.

5.1.2.7 Yearnings

Carey felt it was worth continuing with the pregnancy so that her daughter could have a sibling. She felt that her labour experience had been worth the effort. She experienced the medical staff as supportive during her delivery. She wanted to become a better parent, and wanted to be at home with her children while they were still young.

She viewed coming to Canada as a new immigrant as “worth it once you think your children have a great future---it’s worth the sacrifice.” She wished her mother was alive so that she could have her support. She also wished that her mother could see her grandson. She wanted her father to be there to provide her with support.

5.1.2.8 Self/I am

Carey had “wanted to die” during the delivery.

5.1.3 Analysis of the social work intervention provided in terms of Satir brief therapy

5.1.3.1 Carey's traumatic birth experience

Carey went to the level of self/I am and spoke of wanting to give up and die during her extremely difficult labour. Researcher went to the level of her perceptions and reframed her experience, pointing out that she had had a lot of strength to be able to continue in the situation. Carey was then able to go to her expectations and have the hope that over time she would heal and things would improve.

Carey went to her expectations and spoke of being convinced that her second labour would be easier than her first labour. Researcher went to her feelings and said that it must have been a shock for her.

Carey went to her perceptions and questioned why she was the only one who had had such a difficult birthing experience. When researcher added the perception that that belief must make it very difficult for her, Carey was able to perceive that the staff had been very helpful, and that she had found that very supportive.

When Carey was crying and said that she wished her husband could stay in hospital with her all the time, researcher increased Carey's awareness and went to the level of her yearnings, saying that she wanted the comfort of having someone present who was close to her. Carey agreed, saying she wanted someone with whom she could talk to at night.

When researcher went to the level of Carey's feelings about her feelings, and asked her how she felt about the fact that she was upset, Carey said she did not feel good about crying. When researcher added the perception that it was normal after what she had experienced Carey could verbalize that she was starting to feel much better every time she cried, and could see that the worst was over.

Later on in the session Carey perceived that she had experienced the worst of the trauma, so her adjustment to her immigration should not be too bad. Researcher stayed at the level of perceptions and suggested that perhaps Carey was now able to see some positive in her birthing experience, in that the worst was over. Carey agreed, commenting that she would be focusing on raising her children. Researcher then went to her yearnings and noted that that might be very meaningful for her and very special as a mother to be with her children while they were growing up. Carey said she would love to do that.

5.1.3.2 Carey's adjustment to her new baby

Carey expected to be busy with her new baby. Researcher went to Carey's perceptions and said that it was a big adjustment for a mother to have a baby again. Carey agreed and noted that even though the first few years would be difficult, after that it would be easier.

Researcher went to Carey's expectations and asked whether the pregnancy had been planned. Carey answered that they had planned on having only one child, but had then decided to continue with the pregnancy. She went to her yearnings and noted that her daughter had always wanted a playmate, and that she felt it had been worth it so that her daughter now had someone to play with. Researcher remained at the level of Carey's

yearnings and added that it was also very special to her and her husband as they had had a little boy. Carey agreed and elaborated on how that was very meaningful for her husband in particular.

5.1.3.3 Carey's adjustment to immigration

Researcher explored Carey's iceberg by asking the reason they had decided to immigrate to Canada. Carey went to her yearnings and said they had wanted a better life. Researcher went to the levels of expectations and added that they had been expecting and hoping for a better future. Carey said that they had not been expecting to have another child at that time. When researcher went to Carey's yearnings and noted that at least she felt that she could offer her children more, Carey agreed, and added that they would have a better education and that it was a better place to grow up in. Researcher then went to Carey's perceptions and commented that it could be difficult for the parents. Carey agreed and then went to her yearnings and noted that it was worth the sacrifice as her children could have a great future.

When researcher asked how Carey was experiencing immigration emotionally, Carey went to her perceptions and said that they had been prepared to leave, as the people in the country they had been living in had not been friendly and it was not possible to obtain their citizenship there. When researcher went to Carey's yearnings and commented that she had not felt that she belonged there, Carey agreed. She noted that it had been a big sacrifice for them, but that they had to immigrate when they were younger, as when they were older it would be more difficult to get into Canada.

Researcher noted that perhaps Carey's perception about life being better in Canada would keep her going through the difficult adjustment. Carey again went to her yearnings, saying they wanted to be able to lead a better life. Researcher went to her perceptions and commented that Carey had to adjust to a new country and to another child, as well as having to recover from her birthing experience.

Researcher then explored Carey's inner experience of having to cope with her husband not having permanent work. Carey went to her perceptions and said it was stressful and sometimes resulted in conflict. She then went to her feelings and described feeling insecure as there was no income and they were spending their savings. When Carey mentioned that they wanted to buy their own home, but in order to do so her husband needed a stable job, researcher went to her perceptions and noted that it took time. Carey was then able to realize that they would have to be patient.

Carey went to her expectations and said that it was not what they had expected as they had thought it would not be difficult to obtain work. Researcher noted that that must have made it even more difficult for them if they had not been expecting it. Carey agreed, going to her perceptions and saying that it would not have been so difficult if she could work. When researcher explored what that was like for her, Carey went to her yearnings and said that she had to accept it as she wanted to raise her son properly and wanted to be a full time mother for a while.

Carey spoke of feeling guilty when her daughter was young and she had had to return to work. Researcher went to Carey's perceptions, saying that at least this time she did not have to return to work. When Carey agreed, researcher reframed that even though she was experiencing financial strain, at least she could be with her children while they were still young.

When Carey spoke of their situation in Vancouver, researcher went to the level of her feelings and said that one can feel insecure in the beginning. Carey agreed, and this allowed her to own that it was very difficult for them. When researcher added that it must be very upsetting, she agreed and went to her yearnings that they were doing it for their children.

Carey then started crying and went to her perceptions, saying that she sometimes questioned their decision to immigrate to Canada. She then went back to her yearnings, saying that if her children were happy that it was worth the effort. Researcher went to her perceptions, pointing out that it was a very difficult transition that they were going through. Carey also went to her perceptions, saying that they had been told by their friends that the initial stages were difficult, but that eventually they would settle down. Researcher stayed at the level of her perceptions, adding that it took courage to immigrate, even though it was difficult.

5.1.3.4 Grieving the loss of her mother

Carey disclosed that her mother had died at the beginning of the year, and started crying. She said that her mother had died suddenly. Researcher went to her expectations and added that she had not been expecting it.

Carey spoke of hoping that her mother was watching over them. Researcher remained at the level of spirituality and said that it seemed as though that was what Carey believed. Carey was able to say that she did believe her mother could see what they were going through, and researcher added that Carey believed that her mother still existed in spirit. Researcher then went to Carey's feelings and said that must be a comfort to her.

Researcher added the perception that it is very hard when a mother dies, especially not being able to return for her funeral. When Carey said she had gone back to see her mother four months before she died, researcher again went to Carey's feelings, saying that that must be comforting for her.

Researcher went to Carey's perceptions, saying that it took time to grieve after the death of a parent. When Carey said she would miss her, researcher stayed at the level of Carey's perceptions, saying that it was understandable. Carey could then go to her yearnings and say that her mother had been the one person she could talk to, especially when she had been pregnant.

When Carey spoke of her daughter knowing that Carey was very sad because her mother had died, but that she thought it was funny when she saw Carey crying, researcher added to Carey's perceptions and said that her daughter did not understand. When Carey said that she had wanted her mother to know her second child, researcher went to the level of her feelings and said that it was a huge loss for Carey. She could then go to her yearnings and talk of her close relationship with her mother.

When Carey spoke of people not being able to believe that her mother was gone forever, researcher went to the level of her expectations and added that it was very difficult when it happened so suddenly, as it was not expected. Carey could then go to the level of her perceptions and say that she had not been able to believe it and had questioned God as to why her mother had been taken away. When researcher added that it seemed so unfair, Carey could go to her yearnings and speak about the consolation she derived from looking at pictures of her mother in the coffin.

Researcher went to the level of Carey's perceptions and added that when a woman has a baby there is a need to connect with her mother, and that this could highlight the loss for her. Carey then went to her perceptions and said that her mother had always given her advice on what to do as regards parenting.

Carey then spoke of her aunt and uncle, in the east of Canada, who kept calling them. Researcher went to the level of yearnings and said that it was helpful to know that there were people who cared. Carey remained in her yearnings and said that they were very

supportive. Researcher said that at least she had that, and that perhaps she would also have her father coming to Canada. Carey remained in her yearnings and said that at least she had that to look forward to.

5.1.3.5 Problem solving and support provided

Researcher and Carey discussed ways of trying to obtain a breast pump more cheaply. Researcher provided information on resources in the community that provided cheaper baby supplies. Researcher also provided information on the process of applying for welfare.

As Carey had expressed the yearning to be a good parent and was open to being connected to a parenting program, researcher linked her to a community program that provided parenting support. Researcher also provided information on how to access counseling and assistance with anxiety and post partum depression, if necessary.

5.1.3.6 Changes in Carey's iceberg during the Satir brief therapy intervention

When Carey discussed her traumatic experience of labour, she was able to acknowledge her feelings, perceptions, expectations and yearnings. When Carey said that she did not feel good about crying about her traumatic birthing experience, and researcher added the perception that it was normal to cry, Carey was able to verbalize that she felt better each time that she cried. She was then able to perceive that “the worst is over I’m feeling now,” and later said that as the worst was over she would be focusing on raising her children. She was also able to explore her yearnings as a mother, wanting to be a good mother and wanting to stay home with her children while they were young.

When researcher tapped into Carey's inner experience of the adjustment process of immigrating, Carey was able to increase her awareness and acknowledge her feelings, perceptions, expectations and yearnings regarding this process. Carey was able to increase her awareness of her yearnings regarding the loss of her mother, and her need for her father to come and join the family in Canada.

5.1.3.7 Carey's experience of the therapeutic intervention

Carey had tried to contact researcher before the appointment that they had made for researcher to visit her at home to discuss her experience of the Satir brief therapy, as she had just twisted her foot and was having difficulty moving around. However, as she had not been able to reach her, she decided to go ahead and see researcher as previously arranged.

During a follow up home visit to evaluate Carey's experience of the social work intervention while in hospital, Carey described her experience as good, that at least she could open up and speak to someone about all her problems. She said that she had to let out her experience of labour and tell someone about it, as it had seemed so unfair to her that she had to have such a terrible experience. She said that she had been feeling much better after such a long time, when she had twisted her foot, the day prior to researcher visiting her at home.

She also said that it was good to discuss her feelings about her family's current situation after having recently immigrated. It had allowed her to let out her frustrations and insecurities regarding their situation.

When discussing the information on resources that researcher had given her, Carey said that she had not been able to obtain any baby clothes. She had met the person from the parenting program, and had agreed to try out the program when her daughter was on holiday.

Carey said that when they had spoken about her mother it had brought up memories, and that it was still very fresh, but that it was good to let it out. She had decided not to go for counseling as she felt that she was coping.

She summed up her experience of Satir brief therapy by saying "It was nice actually to meet someone and share all the experiences and grievances and whatever feelings you had about the delivery. That was especially difficult, and I needed someone to talk to, and it was good."

5.2 Tara*

5.2.1 A description of Tara's situation

Tara is a 25 year old woman who delivered her first baby vaginally at 39 weeks gestation. Her nurse made out a social work referral as Tara is a single mother, and may

* Fictitious Name

have needed assistance with baby supplies and supports in the community after discharge.

Prior to her pregnancy Tara experienced depression, for which she had been treated. Tara saw a psychiatrist during her pregnancy, as she was not receiving emotional or financial support from the baby's father and was experiencing great difficulty coping with her unplanned pregnancy.

Tara experiences good support from her family and friends. She lives on her own in a basement suite. Her married sister lives next door to her on the one side, and her best friend lives next door to her on the other side of her home. Her uncle lives in the upstairs suite of Tara's sister's home. Tara's mother lives in the east of Canada and she is in regular contact with her. Tara receives maternity benefits from employment insurance as well as a welfare top up.

Tara was on a ward where women have uncomplicated births, and may go home the day following delivery. Although she was very sleep deprived, having had only four hours sleep in two days, she was keen to see a social worker to learn more about resources for herself and her baby in the community. As she was being discharged later that day, she decided to see researcher instead of sleeping. Researcher had one session with Tara

5.2.2 Tara's iceberg

5.2.2.1 Behaviour

Tara was attentive to her baby's needs and was bonding with him.

5.2.2.2 Stance

It appeared that Tara may be a placator, from what she said about being a hairstylist: "I don't like not being able to please someone. I like being able to please someone to look good, and if they don't like what I'm doing I'm going to be devastated."

5.2.2.3 Feelings

Tara had been devastated at the diagnosis of her pregnancy. She was very excited after she had delivered her baby, and was proud of the way she had coped during labour.

She was anxious and fearful as to how she would cope long term on her own, without any assistance. She was very hurt and disappointed that her baby's father had not remained actively involved as he had told her that he would. She was angry that he was very comfortable financially, but was not providing financial assistance, while she was

struggling financially. She was also hurt by his negative statements about her as a person and as a mother. She was sad at the loss of a partner for herself and a father for her baby.

She was ashamed of her basement suite, and felt it was “the worst place I’ve ever lived in.” She was scared of suffering from post partum depression, that “the blues would become the blacks.”

5.2.2.4 Feelings about feelings

Tara did not feel good about her negative perception of single mothers.

5.2.2.5 Perceptions

Tara thought that she had coped very well during labour. She was unsure of the degree of involvement and assistance that her baby’s father would provide.

She realized that motherhood would be demanding. Tara has confidence in her ability to parent: “I know I am capable of taking care of my son.”

Tara perceived single mothers as “young little airheads who don’t have it straight.” She considered that she had “screwed up” because she is a single mother. She also saw her living conditions as having deteriorated.

Tara viewed herself as an intelligent young woman. She considered herself to have value and to be a worthwhile person: “I didn’t deserve to be treated badly while I was pregnant. I didn’t deserve to be told that I was crazy-----that I wasn’t going to be a good mother.”

(Tara was referring to the way her baby's father had treated her.) She had confidence in her ability to cope in life, even if she were to be without her support systems.

5.2.2.6 Expectations

Tara had not expected to be pregnant at 25 years of age. She had expected to be treated well by her baby's father during her pregnancy. She had also expected that her baby's father would have remained involved, and would have visited her and been present during the birth of her son.

She had expected that when she was pregnant that she would have had a partner, just as her brother and sister had. She also expected that her standard of living would have remained on the same level as it had been previously. Tara expected that her family would provide active support.

5.2.2.7 Yearnings

Tara spoke about her great love for her baby and derived meaning from this: "I love that baby more than anything. I have a purpose, whereas before I was just living." She yearned to have a partner and for her baby to have a father.

She experiences a lot of love from her mother: "My mother has always been there for me and we're the love of her life." Tara also experiences being well loved and supported by her siblings.

5.2.2.8 Self/I am

This level was not tapped into.

5.2.3 Analysis of the social work intervention provided in terms of Satir brief therapy

5.2.3.1 Adjustment to motherhood

When Tara spoke of her feelings about being able to cope continuously with caring for her son, researcher added the perception to these feelings that it was normal to have ambivalent feelings about having a baby, which brought Tara to the level of her feelings about her feelings, and reinforced her perception that it was acceptable to experience some ambivalence.

5.2.3.2 Tara's feelings about her baby's father

Researcher helped Tara to explore her feelings about her baby's father. Tara was able to acknowledge her hurt and disappointment at being let down by him, and was then able to go to her perceptions and verbalize that she knew she could manage to care for her baby on her own. When researcher increased Tara's awareness of her sense of confidence in her abilities, Tara could then go to her feelings and express her anger towards him. When researcher added to Tara's perceptions that it was normal to be experiencing anger, Tara could go to her expectations of how she wanted to be treated with respect.

5.2.3.3 Tara's adjustment to being a single mother

Researcher helped Tara explore the different levels of her iceberg in relation to her experience of being a single mother. When Tara spoke of not being able to accept her situation, researcher tapped into her expectations to help her explore further and increase

her awareness. Then when Tara went to her perceptions of how she felt she had made a mess of, and had difficulty accepting, her situation, researcher went to her yearnings, that the present situation was not what she had hoped for. Tara was then able to go to her perceptions and say that she realized that even though she was not happy about the situation, she would have to live with it. She also felt that it was difficult as she had a son and a boy needs a father. Researcher was able to increase her awareness of the sadness she experienced in that regard.

When Tara spoke about feeling ashamed of her housing, researcher increased her awareness of her high expectations of herself, which took Tara to her perception of her situation having deteriorated. When researcher added the perception that that was a temporary situation, Tara was able to increase her awareness that things would change and that she would have to work at that. Researcher then added another perception to ask whether her living situation was a reflection of her value as a person. This increased Tara's awareness and she realized that she need not feel too ashamed of her home. Researcher then used reframing to point out that even though she was in a smaller place, that she had demonstrated courage in deciding to continue with the pregnancy on her own. This led Tara to her yearnings, when she acknowledged that having her baby was very meaningful to her and had given her a purpose in life.

5.2.3.4 Problem solving and support provided

Problem solving occurred as to who Tara could call on to relieve her for a while with baby care. Researcher offered to assist Tara by faxing in the confirmation of her baby's birth to her financial worker at the local welfare office, so that her baby could be placed

on her file. This would mean that she would not have to go in to the office with her baby. Researcher provided information regarding places with cheaper baby supplies, food banks and breastfeeding clinics.

Researcher and Tara discussed Tara's previous experience of depression and the risk of post partum depression. Researcher provided information on resources Tara could access in this connection, if needed. Researcher also provided information on a parenting support program.

5.2.3.5 Changes in Tara's iceberg during the Satir brief therapy intervention

When researcher explored Tara's yearnings and added that the situation was not what she had hoped for, Tara was able to come to the realization that even though she was not happy with the situation, she would have to live with it.

When Tara spoke of her situation having deteriorated, and researcher added the perception that the situation was temporary, Tara was able to perceive that her situation would change, and that she would have to work at effecting the change. When researcher reframed her perception and said that even though she lived in a small place, she had demonstrated courage in continuing with her pregnancy, Tara was able to acknowledge this, and then was able to go to her yearnings and explore her feelings about her baby.

5.2.3.6 Tara's experience of the therapeutic intervention

During a follow up visit at Tara's home to evaluate her experience of the social work intervention while in hospital, Tara described her recollection of the therapeutic

intervention as a “blur.” She could not remember what had transpired during the session, and described herself as having had six hours of sleep in two days at that time. She said that she thought it had probably given her more confidence just to be able to talk to someone and let that person know about her situation, as she has a need to express her feelings. She was happy with the resource material that researcher had provided, which she intended to follow up on.

5.3 Kim*

5.3.1 A description of Kim’s situation

Kim is a 26 year old woman who delivered her first baby, a daughter, by caesarean section at 37 weeks gestation. The baby was healthy, but needed treatment for dislocated hips, which had not been known prior to delivery.

A social work referral was made out as Kim is a single mother, and there was concern in case she did not have adequate resources for herself and her baby. Kim’s pregnancy was unplanned. The baby’s father ended his relationship with Kim prior to the diagnosis of her pregnancy, when he moved in with another woman. When her pregnancy was discovered, he wanted her to have an abortion. After she decided to continue with the pregnancy, he withdrew and remained uninvolved.

Kim lives with her mother, whom she experiences as extremely supportive. She also has a married brother and his family living in the greater Vancouver area. She and her family

* Fictitious name.

immigrated to Canada several years previously. Kim, her mother, and brother were accepted into Canada, while her father, sister and other brother were not. Her parents subsequently divorced. Kim says she has come to accept this situation regarding her family.

Kim receives maternity benefits from her place of employment. Her mother assists her financially. She had the basic baby supplies.

Researcher saw Kim for three sessions during her stay in hospital. The first session was interrupted by Kim's mother who had come to visit, and ended very soon after her arrival. Subsequent sessions were held with Kim on her own.

5.3.2 Kim's iceberg

5.3.2.1 Behaviour

Kim cried when talking about the loss of her relationship, and her realization that she would be receiving love from her baby. She was very attentive to her daughter, and was providing appropriate baby care.

5.3.2.2 Stance

It appeared that Kim is a placator, as she was overwhelmed by her feelings of anger initially, and was very uncomfortable with these feelings.

5.3.2.3 Feelings

Kim had been very upset at being let down by her baby's father during her pregnancy.

She was very happy that she had delivered. She was very happy to see her baby and to be a mother.

She was anxious about breast feeding and about all the tasks of motherhood that she would have to perform. Her baby had a health issue, and she was worried about that. She felt stressed by her mother's high expectations of her baby care.

Kim was upset and angry that her baby's father was not taking any responsibility for his baby and had disappeared. She was anxious about the future.

5.3.2.4 Feelings about feelings

Kim felt "bad" about her feelings of anger towards her baby's father.

5.3.2.5 Perceptions

Kim clearly understood that social work intervention was available to provide assistance, especially with support regarding emotions, during the perinatal period. She revealed that she had needed to speak to someone during her pregnancy about her problems, but did not because she thought that if she expressed her emotions that this may harm her baby. She thought that her baby's startled response was due to her experiencing stress during her pregnancy. She thought that perhaps her feelings of sadness and anger could affect her breast milk, and that these feelings could then be transmitted to her baby.

She thought that her mother pushed her too much as regards providing baby care. She realized that her family wanted her to improve on her skills as a new mother, but did not want them to push her too much. She realized that it took time to learn to do things properly. After speaking to her nurse, she realized that it was important for her to try to remain calm, as this would have a positive effect on her baby care.

She understood that her baby's condition of dislocated hips could be corrected medically. She also realized that it was a temporary condition and that "it could be worse."

Kim regards herself as a very sensitive person. At times she saw herself as a "loser", and questioned what she had done to result in her baby's father ending their relationship. At times she regarded herself as ugly, and thought that that was perhaps the reason he had left her. She thought of what happened with her baby's father constantly and blamed him for what she was going through. However, she realized that this was not healthy and that she would have to come to accept that she is on her own.

After her delivery she saw herself as being stronger and was more confident that she could manage on her own with her baby.

5.3.2.6 Expectations

She felt that her mother had high expectations for her as a new mom. She had not expected her baby to have medical problems but expected that she would be able to cope with the necessary medical follow up. She had not expected to be a single mother.

5.3.2.7 Yearnings

When her boyfriend withdrew his support once she had decided to continue with her pregnancy, Kim felt very alone. However, she did experience support from her family, especially from her mother.

She was bonding with her baby: “She’s very close to me. There’s like a bond, a connection. She acts like she knows me for a long time.” Kim wanted to do her best to make her baby happy, to be a good mother. However, she felt very alone as a single parent.

5.3.2.8 Self/I am

This level was not tapped into.

5.3.3 Analysis of the social work intervention provided in terms of Satir brief therapy

5.3. 3.1 Adjustment to motherhood

Researcher explored Kim’s iceberg by asking what her experience of motherhood was like for her. Kim was able to speak of her feelings of happiness, but also mentioned having worries. Researcher increased Kim’s awareness by noting that she was anxious. Researcher then went to her perceptions and spoke of Kim experiencing added responsibility as a parent. Kim was able to stay in her perceptions and say that her mother pushed her too much. Researcher increased her awareness that these expectations made her more anxious. Kim perceived that her family wanted her to improve on her skills as

new mother, but noted that that took time. Researcher added that she was a first time mother.

Kim could then go to her feelings and say that although she was worried about her baby's recovery, she was so happy to have her baby. Researcher went to her yearnings and noted how special this was for Kim. This allowed her to increase her awareness of her feelings for her baby, also realizing that the negative aspect of that was that she was very concerned about her baby's future. Researcher then took this to the level of Kim's perceptions and her concern about her baby's medical condition. Kim was then able to realize that she should try to calm down and take it one step at a time.

5.3.3.2 Kim's feelings about her baby's father

Kim spoke of seeing herself as a loser and thought that perhaps she was ugly and that was the reason her baby's father had ended their relationship. She mentioned that she sometimes felt upset and angry with him and that she felt bad at times about feeling angry. Researcher went to her perceptions and noted that Kim did not feel comfortable being angry. Kim said that usually she was able to forget about things but that she continually thought about this. Researcher noted that it was hurtful and thought that if Kim spoke to someone about it that it could be helpful for her. Kim then spoke of having heard the belief that if she spoke about her anger that those feelings would be transferred to her baby. Researcher was able to add to her perceptions that whether or not she expressed her anger, it was still present and could affect her interaction with her baby unless she started to work through it so that she could come to cope with it.

Kim was then able to continue and said that she realized that she had to accept that the relationship was over. Researcher added the perception that that would take time and that her feelings of anger were normal. Kim could then realize that things would work out, and was able to explore her yearnings regarding her daughter.

Kim: "Yeah. It will be okay. On the other side, I feel very happy because I am a mother and I feel the baby is part of me.....She will be the only one. It will just be me. I will be the only one looking after her, the closest person she will have, and that will be okay.....She makes me think that even though he finished our relationship there is still another good thing." (Crying)

R: "I'm wondering what your tears are saying?"

Kim: "She gives me a lot of love without asking. She's so small, so tiny. Her father was the first one (with whom she had had a relationship). I was asking a lot but she changed my life for good."

R: "There is that to think about and focus on."

Kim: "I am more happy than before. I found a reason to be. Now I have to be accepting."

R: "It sounds as though even though it was such a devastating experience not to be able to receive the love you were asking for, you realize it is going to be the love for your daughter, your relationship with her, that makes it very special."

Kim: "She is so beautiful and she is special. It is like triple the love I had before. I have to be strong, do more things than before."

5.3.3.3 Problem solving and support provided

When Kim spoke of having to attend numerous doctors visits with her daughter, to see to her hips, and said that she did not drive and that it might be difficult to take her newborn daughter on the bus, both researcher and Kim engaged in brainstorming transportation options. Kim's baby required bigger clothes due to the problem with her hips. As most of the clothes that Kim had for her baby were small, researcher gave her one or two larger baby items, as well as a list of places with cheaper baby clothes.

As Kim is a first time mother without the support of a partner, and her own mother, although very supportive, is working, researcher linked her to a parenting program which provides support to new mothers. Researcher provided information on resources in the community that Kim could access if she had the need, including counseling resources and a resource which provides assistance with anxiety and post partum depression.

5.3.3.4 Changes in Kim's iceberg during the Satir brief therapy intervention

When researcher tapped Kim's yearnings and increased her awareness that while it was a very special feeling for her to have her baby, it also meant that because her baby was so special that she would be more concerned about her medical condition, Kim able to perceive that she should calm down and "take it one step at a time."

Once Kim had become more aware of her anger, and could acknowledge and own this, she was able to free up her energy and explore her yearnings, finding that the love she shared with her baby was like "triple the love" she had experienced with her baby's

father, and she was able to come to accept the end of their relationship. She then felt free to concentrate on bonding with and caring for her baby.

5.3.3.5 Kim's experience of the therapeutic intervention

During researcher's follow up visit at Kim's home to evaluate her experience of Satir brief therapy, Kim said that it had helped her to discuss her feelings: "I felt confused and everything and you helped me to take out feelings that I couldn't take out, so after that I was able to think more, better.....and then I was more ready to put more energy in what I was doing.....now I feel I can do everything."

Although she felt "I am still not one hundred percent, but I can see the difference.....After I spoke with you something made me think about my daughter, and sometimes I didn't think about her too much before, so it makes me realize that I have to do well for my daughter." She said that after the intervention she had started to become stronger and to realize that what had happened to her was not too bad, and that she was not the only one with those kinds of problems.

5.4 Eva*

5.4.1 A description of Eva's situation

Eva is a 34 year old married woman, who delivered her first baby, a son, vaginally, at 34 weeks gestation. She experienced the delivery as very traumatic, as she had started labour at home and had not realized that she was in labour. By the time her husband called for an ambulance, she was in active labour and she delivered shortly after reaching the

hospital. Her baby was transferred to the intermediate care nursery after delivery, as he was premature. When her baby was medically ready to be discharged from hospital, Eva broke down emotionally and told the nurses she did not feel ready to take him home. The medical staff was very concerned and the baby's nurse made out a social work referral in order to assess Eva's situation.

Researcher met with Eva, who felt overwhelmed, and did not feel emotionally ready to cope with her baby on her own at home. As her baby had been in the nursery since birth, she had not had the opportunity to room in with him and to provide baby care on a continuous basis. She was agreeable to rooming in with her baby in the hospital, and researcher advocated with the medical staff so that this could occur. Eva remained in hospital for over a week with her baby.

For the first few days she was extremely fragile emotionally. Researcher provided counseling to Eva regarding her traumatic birthing experience. When Eva's feelings of loss and abandonment surfaced regarding her mother, who had abandoned the family when Eva was twelve years old, researcher provided support and counseling. Researcher used Satir brief therapy to address both these issues, but did not ask Eva at that time whether she wanted to participate in the research study, as researcher felt that Eva was too overwrought to cope with anything else. However, as time neared for the discharge of Eva and her baby, researcher felt that Eva was now in a position to consider whether she wanted to participate in the study. Eva agreed to be included in the study, and researcher

* Fictitious name.

has used Eva's last session in the hospital prior to discharge as part of the research study. The focus during this session was on how Eva felt about her imminent discharge with her baby.

Eva's pregnancy was planned. She would be on maternity leave and would be receiving maternity benefits from her place of employment. Her husband was working in two jobs, and Eva was experiencing financial stress.

She has no family support in Vancouver. She has a brother who lives in another part of Canada. Her father is alive, but she does not regard him as being available to provide support. He immigrated with Eva and her brother to Canada when his wife abandoned the family when Eva was twelve years old and she took on the caregiving role for her younger brother.

5.4.2 Eva's iceberg

5.4.2.1 Behaviour

Eva provided appropriate baby care to her baby during the session and was bonding with him. She cried during the session when she spoke of feeling alone.

5.4.2.2 Stance

It appears that Eva has the super reasonable stance, as she tends to process events intellectually.

5.4.2.3 Feelings

Eva felt less irritable after managing to have some sleep. She was scared of going home and felt insecure without having a support person there to help her. She feared losing her identity, and felt she would not be happy without having some social interaction.

She felt happy about having her baby. She was anxious as to how she would manage to work and adequately care for her child. She was worried that she would be laid off from her job after her maternity leave.

5.4.2.4 Feelings about feelings

This dimension was not tapped into during this session.

5.4.2.5 Perceptions

Eva realized that giving birth triggered her memories of abandonment by her mother when she was twelve years old. Eva perceived her baby as being very demanding and found feeding him was very time consuming. She thought that she was more confident with baby care than she had been when she started to room in. Eva perceived that she had lost her freedom. She realized that it is very difficult to balance work and caring for one's children.

5.4.2.6 Expectations

Eva felt that society expects that women should cope with the dual roles of parenting and working.

5.4.2.7 Yearnings

Eva wished that her mother was there to help and support her.

5.4.2.8 Self/I am

This level was not tapped into.

5.4.3 Analysis of the social work intervention provided in terms of Satir brief therapy

5.4.3.1 Eva's own lack of mothering

Researcher tapped into Eva's yearnings regarding her own lack of mothering as a child.

Eva could recognize that having a baby had triggered these memories.

5.4.3.2 Adjustment to motherhood

Researcher explored Eva's feelings regarding being discharged shortly from hospital with her baby. Eva spoke of feeling a bit scared as she would be on her own. Researcher went to her perceptions and established that her husband would be home for the first two days after discharge. Researcher also queried whether Eva felt she had acquired baby care skills while in hospital.

Eva: "Yeah. I've learnt at least how to care for him. There's still a lot to learn, but you learn as you go. At least I have some idea what to do. The first time I didn't know what to do."

R: "So you're not totally at a loss."

Eva: "Exactly, yeah."

When Eva again mentioned that she felt uncertain at being alone at home, researcher probed into her feelings. Eva said she feared she would feel lonely or bored. When researcher asked what she normally did when she was on her own and her husband was working, Eva spoke of participating in activities with other people. Researcher then went to her yearnings and noted that perhaps it was the company that Eva was going to miss. Eva thought that that was the reason and then expanded on her need for company. Researcher went to her perceptions and added that it was a big adjustment. This allowed Eva to expand on her yearnings.

Eva: "I want to care for my kid but I also need a life outside. If I take away the social, my own identity, and just me and the kid, I don't think I would be happy."

She spoke of the trend in society for women to have to do everything. Researcher noted that those were the expectations from society. Eva went to her perceptions and concluded that it was not possible to work full time and care for one's children full time. Researcher went to her yearnings and noted that Eva knew what her needs were, that her identity was really important and she did not want to lose that. Researcher then went on to her perceptions and said that it was an adjustment and she would have to see what worked best for her. Eva spoke of not realizing previously how fortunate she had been to have her freedom.

Researcher explored Eva's iceberg by asking what it was like for her to have a child.

Eva: "Inside I'm happy, outside (laughing) I don't know, outside it's more like, help, I need help!"

Researcher perceived that it was a bit chaotic and Eva agreed. The following are excerpts from how researcher helped Eva to explore her yearnings and the universal life force:

R: "-- it sounds as though inside it's a good thing for you?"

Eva: "Yeah."

R: "What does it do for you?"

Eva: "It's, having a baby, it's special. It's a special feeling. When you have a baby you are giving, you are nurturing. You just feel in your heart you have so much love to give, and that gives you a special feeling that you can do that.-----This is my baby! It's really amazing. I believe there's a God, I believe there's a God!"

R: "There's something bigger than ourselves in order for something like this to happen."

Eva: "Yeah.-----I should be happy. Like, what are you complaining about, speaking about being scared about going home, this and that, too much work, but these are minor! The most important thing is that he's healthy.....What else do you want?"

Eva also came to the realization that she and her husband were not the only ones who did not have any support

5.4.3.3 Problem solving and linking with supports

Problem solving occurred regarding how Eva could cope more effectively with chores at home. Researcher and Eva discussed how Eva could maintain her social contacts. Also,

how she could receive parenting support, as well as possibly increasing her social contacts, by attending parenting groups in the community.

As Eva was concerned that she may be laid off when she returned to work, she and researcher brainstormed other occupational possibilities for her now that she had a child. Researcher provided information on vocational testing at Eva's request.

Researcher linked Eva to a parent support program for first time mothers. She also informed Eva of a parenting resource with an outreach counselor, who assisted mothers who were feeling overwhelmed by anxiety or depression - Eva was aware that there was a waiting list for this service, and that even though researcher had already called in and spoken to the counselor, that she would have to call in to put her name on the list. Researcher informed her of another resource she could access for anxiety or depression, which she could call and speak to someone on the telephone, or attend a group. Eva was aware of the possibility of being able to access Reproductive Mental Health at the hospital, which provides psychiatric services to women during the perinatal period.

5.4.3.4 Changes in Eva's iceberg during the Satir brief therapy intervention

The therapeutic intervention assisted Eva to explore her fear about going home with a new baby, and to increase her awareness of her yearnings for social contact and her need to be able to retain her identity.

Eva was able to explore her yearnings regarding her baby and was able to realize how special it was for her to have her baby. She realized that the most important thing was

that he was healthy, and that her concerns about being scared to go home and about it being too much work were minor in comparison to his health. She was also able to realize that she and her husband were not the only new parents who did not have support for themselves.

5.4.3.5 Eva's experience of the therapeutic intervention

During researcher's follow up visit at home, Eva said that she had found the therapeutic intervention in the hospital helpful. She had found it helpful to have someone to talk to about her feelings, and had found it helpful to have information about resources in the community.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

Introduction

The results of the research are evaluated. The objectives of the study are given and changes which occurred in the patients in terms of these objectives are described. The research question regarding the effect of Satir brief therapy in a maternity hospital with medically high risk patients is answered and the implications for the use of Satir brief therapy in perinatal hospital social work are discussed. Recommendations are made concerning further research and the role of perinatal social work in a maternity hospital.

6.1 Objectives of the study

The objectives of the study were to

- effect first level change i.e. to create new awareness and find solutions to problems.
- effect second level change i.e. to transform feelings, perceptions, expectations and/or yearnings.
- effect third level change i.e. to effect change at the level of the self/soul.

6.2 Conclusions

The conclusions of the research are now discussed in terms of the objectives listed above as it pertains to each woman.

6.2.1 First level change i.e. to create new awareness and find solutions to problems

As can be seen from the women's icebergs, first level change was achieved with all four patients. Awareness was increased in all four women's perceptions, feelings and expectations. All four women were able to explore their yearnings and find meaning in the love they experienced for their babies.

6.2.2 Second level change i.e. to transform feelings, perceptions, expectations and yearnings

6.2.2.1 Carey

Carey was able to integrate the trauma of her delivery during her session of Satir brief therapy. It appears that she experienced second level change when she was able to let go of the negative energy she had experienced during her traumatic labour and was able to focus her energy on the issue of raising her children. The fact that Carey was motivated to receive therapy in order to address her traumatic experience of labour indicates that she was in the contemplative stage of change, which is a prerequisite for a successful outcome in brief therapy.

6.2.2.2 Tara

Second level change did not occur with Tara. There are a number of possible reasons for this. Tara had been in the pre-contemplative stage of change. Her motivation for seeing a social worker had not been to address any of her psychological or emotional issues.

Rather, she had wanted information on resources in the community for herself and her

baby. Even if she had wanted to effect some change intrapsychically, it is possible that her sleep deprivation would not have allowed for this.

Tara received only one session of Satir brief therapy. This was a lengthy session, as she had needed to express her feelings about her situation, and it had been necessary for researcher to complete a full social work assessment prior to her discharge home with her baby, as she was at high risk for post partum depression. It is possible that the length of the session added to her fatigue.

Although Tara had been treated for depression and obsessive thoughts previously, this did not appear to be a concern while she was in the hospital, and it is researcher's opinion that this did not affect the potential for second level change.

6.2.2.3 Kim

Kim was very aware of the role of perinatal social work once she agreed to participate in the research study, as she had read the letter of consent very thoroughly. However, although she was aware that her intrapsychic issues needed to be attended to, she was ambivalent about this at the beginning of her contact with researcher. As therapy progressed, she was able to let go of her ambivalence. It is possible that her perception of researcher was a good fit for what she described she wanted in a therapist, i.e. someone who was mature and whom she could trust, and that this assisted her in being more comfortable to go ahead with attending to her issues.

Kim experienced second level change when she was able to let go of the negative feelings she had experienced towards her baby's father and the ending of her relationship with him, and instead focus positive energy on the love she felt for her baby and the meaning that this provided for her.

6.2.2.4 Eva

Second level change occurred with Eva when she was able to explore her yearnings of what her baby meant to her. She was then able to let go of her previous concerns, like her uncertainty about coping and her fear about baby care being too much work, and she was able to appreciate the special meaning that her baby had for her. She was also able to see that she and her husband were not the only ones who did not have support regarding baby care. It is possible that as Eva's emotions had been aroused due to the crisis she experienced during and after labour, she became more open to being able to use therapy in order to effect change.

6.2.3 Third level change i.e. to effect change at the level of the self/soul

Transformation at this level was not applicable with these clients, as none of these women's issues were such that they needed to make a decision about whether or not they wanted to live. Although Carey had expressed that during labour she had wanted to die, she was not at that stage when researcher started providing therapy. During therapy she was able to perceive that the worst of her traumatic experience was over.

6.3 The research question: What effect does Satir brief therapy have on patients in a maternity hospital?

The results indicate that the use of Satir brief therapy supports the research question and does bring about first level change in patients in a high risk maternity hospital. However, it does not indicate that second or third level change will necessarily occur.

6.4 Implications for the use of Satir brief therapy in perinatal hospital social work

The results of this study indicate that Satir brief therapy can be used in a maternity hospital for women with medically high risk pregnancies as a treatment model to address the psychological and social issues which can affect the mother - baby dyad, thereby promoting healthy mother - baby bonding.

As the time period in which therapy can be provided is often so brief, the goals of the interventions need to be clearly defined in terms of the woman's concerns as this affects the mother baby relationship. The metagoals of Satir brief therapy, namely: increasing self esteem, increasing congruence, and becoming a better choice maker, may occur as a result of achieving the aforementioned goals, but would not be the focus of the interventions.

If used within an extremely brief time period, it may be possible to address only certain dimensions of the women's experience, as appropriate.

The role of perinatal social work needs to be clearly understood by the patients in order for these interventions to be used most effectively. In order for the patients to have a full

understanding of this role, the medical staff also needs to be fully informed of the nature of the perinatal social work role, which encompasses providing counseling for many psychological and social issues in addition to addressing child protection, financial and housing concerns.

It should be noted that all the women in the study were postpartum. These women generally spend a minimal amount of time in hospital, in comparison to women who are hospitalized on the antepartum ward. Social work interventions with women antepartum, as well as with women who are outpatients, will provide a longer time frame in which to provide therapy, and therefore a greater opportunity to effect change using the Satir model.

The Satir model is very useful as an assessment tool for social work intervention during the perinatal period, as it evaluates both the intrapsychic and interpersonal dimensions of a woman's' situation. When used postpartum in this study, it provided an assessment of the mother's behaviour, her behaviour towards her baby and her ability to provide baby care. It provided an impression of the stance she adopted under stress, and allowed for an assessment of her perceptions of her situation, of her baby, of her ability to parent and of her support systems. The model provided an assessment of her feelings about her pregnancy, her experience of labour, about being a parent and about her ability to cope in the situation. It provided an assessment of her feelings about her feelings. The model provided an assessment of her expectations of herself as a mother, of her baby, of her

partner, of the medical staff and of her support systems. In addition, it provided information about her yearnings, and of the meaning her baby held for her.

6.5 Recommendations

6.5.1 That further experimental research is undertaken to assess the effectiveness of the use of the Satir model in a maternity hospital.

6.5.2 That education is provided to the medical staff in the maternity hospital regarding the scope of the role of perinatal social work.

6.5.3 That brochures are compiled outlining the role of perinatal social work. These can be distributed to both patients and the medical staff in the maternity hospital.

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APPENDIX 1 – WORKLOAD MEASUREMENT SYSTEM

BCW Social Work Count of Patients by Diagnosis

Diagnosis	Year 2001/02	Year 2002/03	Grand Total
Blank	306	478	784
Accommodations (Client)	75	168	243
Accommodations (Family)	33	16	49
Adjustment to Hospitalization	94	40	134
Adjustment to Parenting	243	205	448
Adjustment to Pregnancy	156	198	354
Adolescent	61	146	207
Adoption-Keeping	5	2	7
Adoption-Placement	18	8	26
Alternate Facilities	1	4	5
Assist with Birth Forms	29	19	48
Assist with Community Resources	361	284	645
Baby Clothes/Supplies	35	142	177
Chemical Dependency – Current	49	43	92
Chemical Dependency – Detox	14	11	25
Chemical Dependency – History	55	144	199
Child Care Arrangements	20	117	137
Child Protection – MCF Clients	90	144	234
Child Protection – Newborn Removals	40	11	51
Clothes/Comforts		1	1
Clothes/Comforts – (mom)	6	2	8
Decisions re Termination		1	1
Domestic Violence – Current	22	116	138
Domestic Violence – History	45	142	187
Family of Origin Issues (Abuse/Neglect)	7	8	15
Family of Origin Issues (Other)	6	5	11
Family of Origin Issues (Separation/loss)	15	10	25
Financial Concerns	202	213	415
Homemaker Help	32	122	154
Immigration/Settlement Issues	103	168	271
Issues with Current Partner	64	34	98
MCFD Newborn Removals		1	1
MCFD Referral – Family Support		4	4
Medical Complications (Baby)	91	152	243
Medical Complications (Mother)	121	181	302

Mental Health (Anxiety)	14	8	22
Mental Health (Current)	22	5	27
Mental Health (Dual Diagnosis)	3	2	5
Mental Health (History)	53	22	75
Mental Health Issues (PP Depression)	14	18	32
Mental Health (Schizophrenia)	2		2
Multiple Birth	32	121	153
Perinatal Loss	53	162	215
Perinatal Loss (0-20 Weeks)	20	24	44
Perinatal Loss SDC	115	53	168
Perinatal Loss (History)	1	8	9
Physical Disability (mom)	4		4
Self-Pay	16	113	129
Special Client	5	111	116
Substance Dependency – Other	5	5	10
Transportation	41	128	169
Total Diagnoses	2799	4120	6919
Total Patients	1213	1108	2321

- Patients may have multiple diagnoses

Note: Due to the method by which Dx was previously collected in the Corporate Workload Measurement System, these numbers are not 100% accurate for those patients whose diagnosis has changed over time. When a previous diagnosis was changed to a new one, the previous diagnosis is lost from the system and we are not longer able to retrieve it for analysis.

APPENDIX 2 - CONSENT FORM

Satir Brief Therapy in a High Risk Maternity Hospital

Principal Investigator: Bertha Cohen. Social Work Department. Telephone 604 875 3788

As a requirement for the completion of a Masters of Social Work degree through the University of South Africa, the Principal Investigator is conducting a research study to assess whether patients at BC Women's hospital benefit from being helped with their social and/or emotional issues by using Satir brief therapy as a form of counselling. Satir brief therapy is a form of professional counselling which incorporates all the different levels of human experience. This clinical intervention empowers patients to build on their personal strengths in order to cope more effectively in their adjustment to parenting. This clinical intervention is limited to a few sessions. The purpose of using this particular therapeutic model is to assess its helpfulness to women in their adjustment to parenting.

Half an hour to one hour counselling sessions will be held as often as you feel is necessary, while you are in hospital. A follow up interview of one hour will be held within 30 days, either in your home or at the hospital, after you have been discharged, to discuss your experience of these sessions. The entire period of time you will be spending on this study will range from one and a half hours to eight hours, depending on your needs

Audiotapes will be used to record the interviews. All information will be kept strictly confidential. You will be given a pseudonym and will not be identified on the audiotapes, transcripts, or academic reports. The audiotapes and data will be kept in a secure place during and after the study. Only two other people will have access to the audiotapes: The researcher's supervisor (the director of the department of social work) at the distance university, who is bound by an oath of confidentiality; and the typist transcribing the tapes, who will be asked to sign a declaration of confidentiality.

Your decision to participate in the study is voluntary. You may refuse to participate, or may withdraw from the study at any time. This will not affect your right to receive social work counselling. You have up to 24 hours in which to consider whether or not you want to participate in the study. You do not waive any of your legal rights by signing this consent form.

If you have any questions I am happy to discuss these with you. If you have any further concerns, you may also call Roberta Costanzo, my supervisor at BC Women's hospital, at 604 875 2926. If you have any concerns about your treatment or about your rights as a research subject, you may telephone the office of Research Services at UBC, at (604) 822-8598.

APPENDIX 2 - CONSENT FORM (contd.)

Satir Brief Therapy in a High Risk Maternity Hospital

Principal Investigator: Bertha Cohen

My signature below indicates that I have received a copy of this consent form and that I have agreed to participate in the study.

I _____ (print full name) consent to participate in the research study and give permission for the interview to be audio taped.

I give permission for the Principal Investigator to reproduce the interviews, in whole or in part, as necessary. I understand that I will not be identified, as my name will not appear on the audiotapes, transcripts, or academic reports. I understand that these research findings may be published and that the results will be available to me on request.

Subject Signature: _____

Date: _____

Signature of Witness: _____

Date: _____

APPENDIX 3 - CLIENT CHARACTERISTICS

Client	Married/ single	Age	Previous children	Financial situation	Recent immigrant to Canada	Support systems	History of depression	History of loss/trauma	Health of baby	Bonding with baby	Baby care skills
Carey	Married	34	5 year old daughter	Struggling	Immigrated recently to Canada	No	No	1.Birthing experience 2.Recent immigration 3.Recent death of mother	Good	Yes	Comfortable with baby care
Tara	Single	25	No	Struggling	Born in Canada	Yes	Yes. Treated medically for this previously	1.Never met her biological father 2.Loss of relationship with baby's father	Good	Yes	Very confident with baby care
Kim	Single	26	No	Struggling	Immigrated to Canada several years previously	Yes	No	1.Parent's separation 2.Loss of relationship with baby's father	Dislocated hips	Yes	Acquiring baby care skills. Very anxious about baby's medical condition
Eva	Married	34	No	Struggling	Immigrated to Canada at 12 years of age	No	No	1.Abandonment by mother at 12 years of age	Good	Bonding gradually	Extremely anxious about baby care. Gradually learning baby care skills

Note: There are only four clients as the fifth client could not be traced.

APPENDIX 4 - INTERVIEWS WITH CAREY

These interviews serve as an example to illustrate the flow of issues with the participants of the study.

First interview

R: "You were saying earlier that you thought it would be really helpful to speak about your experience during labour, because it sounds as though it was very difficult for you."

Carey: "It wasn't what I expected. Like everyone was saying, it should have been much easier and quicker, but it just took me by surprise and it was very disappointing. I had to suffer such a lot. Anyway, it was worth the effort. I was expecting the delivery to be over in five and a half to six hours."

R: "Uh huh."

Carey: "I got admitted at five in the morning and the baby was delivered at six or six thirty in the evening."

R: "Uh huh."

Carey: "And it was difficult because it took me time to dilate and the contractions were so painful and I was not supposed to push out, which was making it more difficult."

R: "They didn't want you to push."

Carey: "No, because they wanted it to dilate to ten centimeters and I just had to survive it. It felt like I wanted to die, actually."

R: "It was so bad."

Carey: "Yeah I would have preferred a c section but it was just out of the question."

R: "It sounds as though it was so hard for you to hang in there."

Carey: "Yeah I felt like giving up at one time and the nurses told me that's what everyone says, that you want to die at this time, but somehow I made it."

R: "So you had a lot of strength to be able to hang on."

Carey: "Yeah."

R: "I'm wondering what helped you?"

Carey: "I just don't know. Maybe I just wanted it over and done with. And my husband, he just said at the end of it all, it was worth it, because we were expecting a girl after the ultrasound. And then it was a boy, and it took us by surprise, so he was saying that it was worth the effort."

R: "So for him it was worth it, and I'm wondering what it was like to hear him say that."

Carey: "Um, it's easy for someone else to say that, but when you look at it at the end of the day, okay, it's your child, so it's worth the trouble. It doesn't matter. Over time it will heal. It will only get better."

R: "Yeah, so it sounds as though it was a very long labour and a very, very painful labour, it was hard for you to hang in there, but you managed. And maybe because it was your second child you thought it would be even easier than the first delivery."

Carey: "Easier, yes."

R: "And not more difficult."

Carey: "That's what everyone told me, so I was convinced it was going to be easier, but maybe I was not lucky with the delivery. Even with my first it wasn't very long, it was nine and a half to ten hours, and I didn't suffer that much. But with this I had more of a problem."

R: "That must have been a shock for you."

Carey: "Yes, it was. I didn't expect it. Because with my daughter I had spotting and I went to the hospital, but they sent me back because my contractions hadn't started by then. I went back for my regular checkup the next day and the doctor said your bleeding is continuous so it's going to be very soon. So at least I was at the hospital, I didn't have to panic. I was there. Soon after that I started having regular contractions, but I didn't have to control the pushing, I could push out of the pain."

R: "Uh huh."

Carey: "I didn't have to control it so it wasn't too bad."

R: "So you didn't have to go against what your body wanted to do, as you had to this time."

Carey: "It was a different experience. My waters broke at 12.30 a.m. and I contacted the doctor who was on call, who said not to come until your contractions start. It started every five minutes but it wasn't very bad, it was just cramping. I was a bit worried so I contacted him and he said no, let it be three contractions for every ten minutes before you contact me again. Which is what happened. After 4.30 a.m. I contacted him and he said, okay, you can come to the hospital. So I thought it would be very soon and it really took time. The pains were getting worse and worse and when he actually told me you can go to the delivery room, I thought, okay, it's going to happen now. So when it didn't happen I was disappointed and I said why does it have to be only me having such a difficult birth."

R: "So it felt as though you were the only one who went through something like this."

Carey: "There may be a few cases but so far from what I have seen and heard while I was down there (in the delivery suite) people were having easy deliveries. I met them."

R: "So maybe at that time there weren't people who went through such a difficult time as you did."

Carey: "Yeah. If there was someone we could discuss our issues."

R: "That must make it very difficult if you feel there aren't other women who have had similar experiences, and then you ask yourself why it should happen to you."

Carey: "Yeah. The staff were very helpful, they were very supportive, which is what I liked."

R: "It sounds as though that was very helpful for you."

Carey: "It was. The nurses in there were very nice."

R: "So that was a positive thing."

Carey: "Yeah."

R: "So at least in what you went through you had the staff who were supportive."

Carey: "Yeah."

R: "With your first delivery, who was there to support you?"

Carey: "My husband was there, but when you actually deliver the child they send the husband out. I had my child in Dubai. Out there they are very conservative, so they don't allow you to watch the whole thing. It wasn't too bad because I didn't have to go through it as out here. If it hadn't been for the nurses who were so helpful and supportive, it would have been worse." (crying).

R: "I'm wondering what your tears are saying?"

Carey: "Maybe I'm just thinking of going through it, of the whole ordeal .It was too much for me. But it's getting better. I think to myself why I have to go through this, why I have to suffer so much?"

R: "You question."

Carey: "Yeah."

R: "What comes to mind when you question?"

Carey: "I just don't know what to think about it .I just accept it. It will get better. I should be okay (crying). I feel bad because my husband can't be here all the time."

R: "So you don't have his support with you."

Carey: "It's not that he doesn't want to be here."

R: "Yes, that must be especially difficult for you, because as you said, you've been through such a difficult time, and although the nurses have provided support, you want the added support of someone close."

Carey: "Yeah I want someone to be with me at night. Someone I could talk to also."

R: "Uh huh. I'm wondering whether you've been able to speak about what happened with anyone."

Carey: "I did. The nurses came and talked to me, so it helps."

R: "Uh huh. You find it helpful to talk about what you have been through."

Carey: "Yeah. Every time they ask me are you okay, and I just answer, and then on my own I start crying, and they come and find me in that state, and they say are you okay and I say I should be okay."

R: "How do you feel that you're upset now about what happened?"

Carey: "I don't feel very good about my crying but I think I should get over it in time."

R: 'Yeah, and it's normal. "

Carey: "It's normal as everyone says, and I am not going to change it, so it's good I let it out."

R: "It's very important that you can talk about it, and it's very normal to be upset after what you have been through."

Carey: "Sometimes I think I am silly crying so easily, but other people say it's just normal, so it's okay."

R: "It's important to be able to speak about it and to express what you are feeling. If you need to cry, to be able to cry. That way you are getting it out and not keeping it inside."

Carey: "Yeah. I'm feeling much better now each time I cry."

R: "It sounds as though it's a relief."

Carey: "Yeah. The worst is over, I'm feeling now. I should get better now once I go back home and lead my normal life."

R: "Right."

Carey: "It's not going to be normal with baby around. It's going to be busy. I have to adjust my routine now."

R: "So it's thinking of that as well, and even though you've been through such a difficult time, you're hopeful that you are going to recover from that, both physically and emotionally."

Carey: "Yes."

R: "Realizing at the same time that it is going to be a big adjustment for you."

Carey: "Yes. I just can't let go. I have my daughter to think about. They all depend on me, so I have somehow to go back to my normal life. It's going to be busy but I have to think about rescheduling everything."

R: "It is a big adjustment for a mom, having a baby again."

Carey: "Yeah. The first few years are going to be difficult when the baby is small. When the baby is grown up it will be easier."

R: "You know from previous experience that it can be very busy in the beginning and then it starts to improve."

Carey: "Yeah. It's now seven years since we had our daughter. We settled down in life, and I did tell myself it's going to be a whole readjustment to everything again. It's not going to be easy but somehow we'll have to manage."

R: "So I'm wondering whether you planned the pregnancy this time?"

Carey: "Well, actually I didn't want to. I was planning on having a single child. But since it happened I might as well go ahead with it irrespective of whether it's a boy or a girl. The second one is going to be our last. I did mention to the doctor that our second one would be our last but he said he cannot take any action until after I have recovered, after six weeks. But after this experience I don't want to go through this again."

R: "It's put the seal on it for you."

Carey : "Yeah".

R: "It's made it completely certain."

Carey: "Yes. Moreover, since the second one is a boy we are happy with that also. There's no going back on our decision."

R: "Why did you decide to have only one child?"

Carey: "I was very happy in my working career. My work environment was very pressurized. I did secretarial work and it was very demanding. My ex boss was not the type to be able to have a second child very quickly. Also, I didn't want to go back to diaper changing and all that stuff, so I decided not to go ahead and have a second one. But when it happened I said I might as well accept it. I didn't plan on having an abortion."

R: "I'm wondering what that was like for you, because you didn't plan to have another child?"

Carey: "At first it was difficult. I wasn't happy about it. But then I said it's not fair to the child. The child has to suffer because I didn't want it. I just accepted it was going to be our last try and go ahead and have the child."

R: "So it sounds as though you adjusted."

Carey: "We just accepted it was going to be our last try and go ahead and have the child."

R: "So it sounds as though you adjusted."

Carey: "Yeah. Even my mom was shocked because after so many years she was wondering, because everyone knew we didn't want another child. I said it doesn't matter. My daughter was always wondering why she too can't have a brother or sister – so I said it's okay, it's worth the effort for her to have someone to play with as she is growing up. She's very happy about it."

R: "For you and your husband it's quite special because you've had a little boy."

Carey: "Yes it is. He wanted it to be balanced to have a boy and a girl and he feels he wanted to have a boy to protect the family in case he's not there. He's very excited about it."

R: "And how do you feel now that you have had a boy?"

Carey: "It took me time to get used to it because with the ultrasound we accepted it would be a girl. After the baby was born it took me time to refer to the baby as a "him." But now I'm getting used to it. I can't imagine that I delivered a boy."

R: "Still difficult to realize."

Carey: "Do you have any children of your own?"

R: "I have two grown up children, two girls."

Carey: "Everyone is excited. My aunt sent a christening dress – what should I do with it? Except for my brother, I don't have any family here. I have my maternal aunt, but she's quite old and not the type to care for children again. I have my cousins too, but they have their own lives to lead and I don't want to be dependent on them because everyone is working."

R: "Do they stay in the Vancouver or Burnaby area?"

Carey: "No, they're in Vancouver and Surrey. We also have friends scattered all over. Where we've taken a place it's far away from everyone, not convenient."

R: "I'm wondering how you find that."

Carey: "It was my brother who decided to take it there and it's in the interior and the bus stop is not very convenient. That bus stop put me off when I came to Canada and I used to be depressed also again – very hilly - I found it very difficult in the beginning."

R: "So you were depressed during your pregnancy?"

Carey: "Yes, a little bit. But then I got used to it. I got used to walking to the bus stop. I used to grumble in the beginning about having to walk so much."

R: "It must have been really difficult because your pregnancy wasn't planned."

Carey: "Yeah."

R: "Then you came to a new country and you were already pregnant."

Carey: "Yeah. I was about four months."

R: "You were pregnant, had to adjust to that, and to leaving."

Carey: "And the weather. It was very cold up here. In Dubai was hot."

R: "Huge change."

Carey: "It was about forty-three to forty-five degrees Celsius (in Dubai) and we found it very cold here and it used to rain – after a month we adjusted to the weather and found it much better. It was one of the worst winters."

R: "What made you decide to come to Canada?"

Carey: "We had relatives who immigrated to Canada in the 60's and India wasn't a very great place for living your whole life. It took us some time, especially with September 11th. We wanted to have a better life. We already had a family so we said we would come to Canada."

R: "Did you leave family behind in Dubai?"

Carey: "Back in Calcutta, India, my parents and my brother. I still have another brother working in Dubai and a sister in Thailand."

R: "So it sounds that you really wanted to come because you were expecting and hoping to have a better future here."

Carey: "Yes, and we didn't plan on having this child at that time. As you can see, that happened, so that's for the best."

R: "At least you feel you can offer your children more."

Carey: “Yes. Definitely. They can have a better education and it’s a great place to grow up in.”

R: “Difficult though, I think, for the parents, because you’re leaving your own familiar life, you’re leaving family and friends.”

Carey: “Yes, that’s what they always say. Coming to Canada is not easy, for the parents especially. It’s worth it once you think your children have a great future and it’s good for your career also. So it’s worth the sacrifice.”

R: “You know that in your head. I’m wondering though how you have found it emotionally.”

Carey: “We were prepared to leave Dubai. I wanted to come to Canada because I liked the place. I hadn’t seen it. Dubai is a great place to make money but not a great place to live in. People aren’t friendly there – even if you spend so many years there you don’t get any citizenship. As long as you have a job you can stay, otherwise you have to go back to your family. So there’s no kind of security out there.”

R: “It sounds as though you didn’t feel you belonged.”

Carey: “No, you can never belong there. When it’s time to leave you leave. So we saved some money and we came here. It was a big sacrifice for us, but we have to do it while we’re younger, we can’t wait until we are older and then it’s going to get more difficult for us to enter Canada.”

R: “It sounds as though you know it’s better, and that maybe that will keep you going. It sounds as though right now it’s quite difficult.”

Carey: “We want to keep going as long as we can. We want to be able to live a good life.”

R: “And I think for a new immigrant it’s an adjustment period, and seems as though you have an adjustment to a new country plus an adjustment to another child.”

Carey: “Yes.”

R: “So you have two things, plus having to recover from what you’ve been through. We were talking earlier with your husband, and he was saying that he doesn’t have a permanent job right now, and I’m not sure what that’s like for you to be coping with that?”

Carey: “Difficult, because at times it gets us both stressed out and we start picking on each other. It’s difficult because right now we have a sense of insecurity – there’s no income, and we’re spending all our savings, which is what we don’t want to do right now, because we are trying to save as much as possible so we can take our own house, which is very important.”

R: “So it’s your plan for the future, your goal.”

Carey: “Yes. We want to take our own house, but it all depends on whether we have a stable job. At least one of us should have a stable job to pay off the mortgage, which is difficult right now.”

R: “It really takes time.”

Carey: “Yes. We have to be patient. We don’t mind having some kind of job, but it’s difficult to get a job. It’s not what we expected. We thought from what we read in the paper, a job shouldn’t be difficult to obtain, but that’s not what is actually happening right now. It is very difficult.”

R: “Yeah. It makes it even more difficult if you weren’t expecting to have to struggle to get a permanent job.”

Carey: "Yes. It wouldn't be so bad if I was working, even if not permanently, even if we were both working on a casual job. It would help. But because I have to depend on him now, we are both finding it very difficult."

R: "As you say, if you were both working, and you have your son and are not able to work right now, and I'm wondering what that's like for you?"

Carey: "It's hard but I have to accept it, because I want to raise him properly. And I decided I am going to breastfeed, because I couldn't do that for my daughter."

R: "What happened with your daughter that you couldn't do that?"

Carey: "Because I went back to work so I didn't have sufficient milk. It didn't help me.

Working at the same time also stresses you out. You start getting to be very short tempered with the baby which is not good. With this one after one year we shall see whether it's really worth it for me to work. Because even sending your child to a daycare takes money, so whether it would be worth working for some job that doesn't pay you well, or staying home and raising your children as a full-time mother. Right now I've readjusted myself so I'm quite okay not working now. I've gone through the worst of it so it shouldn't be too bad. I have to adjust myself. I need some set time for things."

R: "You're thinking how you can do it to make it easier for yourself."

Carey: "Yeah and if I'm organized I should be okay."

R: "It sounds as though physically you've been through the worst."

Carey: "Yes, I have."

R: "And . . ."

Carey: "I was very scared about the delivery because I knew about the experience of delivering a child, and that's what makes it worse – when you know what you have to go

through. What I didn't expect was something that was worse than this -which wasn't very good, that my first one was much easier."

R: "But it sounds as though now, some of the time you're trying to look at your experience and shift it a little bit, so that you see a little bit of positive in that maybe the worst is over."

Carey: "Yes. Now I have to concentrate on raising him and my daughter too, so it shouldn't be very bad. That's the great thing about growing up, actually."

R: "So it sounds as though there might be a lot of positive there for you."

Carey: "Yes, definitely."

R: "And very special as a mom, to be able to be with your children, and as you say, see them growing up."

Carey: "Yeah. I would love to do that. I wouldn't want to go back to work if I can, especially when the children are small. Somehow I find it's not fair to them. Because I remember leaving my daughter when she was about a hundred days old and I had to go back to work and she was crying when I left her at the babysitter and I felt very guilty."

R: "I can see even now when you talk about it, it's upsetting you."

Carey: "Yes. She got used to the idea after a few days, but then I could not give her my full attention."

R: "And it sounds as though it was a very difficult time for you."

Carey: "It was because she was a difficult baby and would wake up every hour and want to feed and I didn't have the breast milk to express and I would become very short tempered due to lack of sleep and tiredness."

R: "Very difficult having a full-time job and having a young baby, and not really wanting to be at work."

Carey: "Yeah."

R: "And then also being sleep deprived."

Carey: "It was, so when she was about two and a half months old I went back to Calcutta to take a break. My mother helped me with my daughter when she was small. It helped quite a bit. It was a good break and she would take over from me in the early hours of the morning so I could have some hours of sleep."

R: "Were you working then or not?"

Carey: "I was still on holiday because we have forty-five days maternity and I took my other leave, so I was able to take off time."

R: "At least this time you're not in that situation, having a job and feeling pressured to go back."

Carey: "Yeah."

R: "So that even though there's financial strain, the positive side of that is that you have an opportunity to be with your children while they're still young."

Carey: "Yeah. When we came over I thought of looking for a job, then my husband said, don't stress yourself out, just stay at home, have a good healthy pregnancy, which is why I didn't pursue it. I was willing to work part-time but he said don't stress yourself. I wasn't feeling very well during the initial stages of my pregnancy, so he said just don't go to work, don't think about it, somehow we will manage - which is why he was very pressurized to work."

R: “So it sounds as though this is what you want – you want to be home with your children.”

Carey: “Yeah, so I won’t stress myself to go to work, it’s not going to help me or anyone.”

R: “I’m not sure whether you know you can claim Child Tax benefits.”

Carey: “I’ve done that and I’m getting an allowance for my daughter and I’ve received a form for my second one, so once I go back home I’ll start applying for it. It does help in a way, which is something good out here, at least you have these benefits. And you have the community centers where you have mother and baby drop-in. I just started going to a pregnant mother’s outreach program – I tried to register at Hastings, Burnaby, it was wait listed, and they sent me to New Westminster, so I attended three of the sessions.”

R: “How did you find them?”

Carey: “It was good because they teach you how to eat healthy, you meet other mothers, they give advice about how to bring up your children, why a child cries, so you come to know many things, which I wasn’t aware of. And it also helped me to get my diet a bit more healthy. Thinking about eating more vegetables. I did speak to them about the mother and baby drop-in. I will try and see if I can go back to Burnaby. In New Westminster it was helpful because they give you a nutritious lunch and a coupon for bus tickets to go up and down and mothers have given baby clothes they don’t want, so I picked some things up, but they were all in pink(laughing). ”

R: “It sounds as though it was very helpful.”

Carey: “It was.”

R: “You learned a lot and found it supportive.”

Carey: "Yes."

R: "I know that eventually you want to buy a house."

Carey: "Yes."

R: "But it's a gradual process."

Carey: "I know, I know."

R: "First getting relief work, then maybe part time, then maybe permanent and eventually to get to that state to meet your goal."

Carey: "Yeah it's going to take time. We would like to be there. We would like a house."

R: "Yeah eventually."

Carey: "We would have taken up an apartment which is much easier and more cheaper to purchase but the advice is that you should take up your own independent house, but we'll just look and see, because buying a house is very expensive in Vancouver."

R: "It is expensive, especially right now."

Carey: "It's very expensive. Everything looks so expensive. If you want cheaper housing you have to move to Surrey and we have to consider other things too.

Sometimes he (her husband) gets a job working is in North Vancouver and that's fine where we are right now but if we move to Surrey he has to travel quite a bit."

R: "Yeah."

Carey: "We don't know what to do. I quite like Burnaby but very expensive. So we just have to wait and see but the main thing is to get a regular job which will take time, I know. Just be patient."

R: "Sometimes it helps if you know people."

Carey: "Yeah. It's good that we have some people we know around otherwise it can get worse."

R: "I know coming from another country that it can be a very insecure feeling in the beginning."

Carey: "Yeah."

R: "Just taking it day by day, not sure what's going to be happening."

Carey: "My husband said I don't know what place you've brought me to, because he was always employed and never unemployed. It's very different for us."

R: "So it seems as though it's a bit upsetting for you."

Carey: "Yeah, very upsetting for him also. And I said we're doing it for our children, and when he sees the facilities here for our children, and we're doing it for our children, then that's fine."

R: "And what are your tears saying right now?"

Carey: "I do think he's correct in a way, he left a secure future in Dubai, and whether we have done the right thing."

R: "You're questioning."

Carey: "Yeah. And if the children are happy, then we say okay it's worth the effort."

R: "It's a very different time right now, the transition you're going through."

Carey: "All our friends keep saying the initial stages are always difficult, you just have to wait, be patient, but you will finally settle down."

R: "It definitely takes time."

Carey: "It may take a year or two."

R: "Sometimes even longer. So I am wondering who made the decision to come, whether you made it together or...."

Carey: "He was planning to go to Australia but I didn't like it and since I have family in Canada I preferred Canada. We both decided we wanted to go elsewhere, which is why we decided to come to this place. I said I'm not interested in going to Australia, so we started looking and applying for Canada."

R: "It sounds you both wanted to move, it was just a matter of deciding where."

Carey: "Yeah. We had heard reports it's not going to be easy. We can't keep waiting forever. As the days are passing it's getting tougher, more people applying, rules getting stricter. We realized we had to call it a day in Dubai."

R: "It takes a lot of courage to do that, to move. And even though it's difficult you've got your goals, you know it's going to take time. Something else that's really important and it seems that you're open to, is actually linking up with the resources in the community round parenting. That seems important to you."

Carey: "Yes. I definitely want to try and improve myself in being a better parent. In Dubai there is no one to advise you. When you have a child to raise it's difficult, you need someone to advise you about many things. I didn't have my mom around me at that time. It would have helped. And my mom passed away this year."

R: "I am sorry to hear that."

Carey: (Crying) "My mom was close to me but it just happened."

R: "It just happened, you weren't expecting it?"

Carey: "No. She was perfectly healthy and had a cardiac arrest. That was it. And I couldn't go back because I was so pregnant. She passed away in January of this year."

R: "It must have been so difficult for you."

Carey: "Yeah. I wanted to go back for her funeral but I couldn't go back."

R: "You couldn't fly?"

Carey: "No I was in my seventh month and after some days after her death I was having a problem with my pregnancy and was taking advice and didn't attend the funeral because it would have make matters worse. I was having a problem with bleeding. It was due to the stress maybe of her death. I would have wanted her to know that she had a grandson, but there's no way to tell her. I hope she is watching over us."

R: "Yeah, so it sounds as though you have that belief when someone dies, I'm not sure..."

Carey: "Yeah, she can see what we're going though. She's watching over us also."

R: "You believe that she still exists in spirit?"

Carey: "Yeah."

R: "That must be a comfort to you."

Carey: "Yes. I keep reminding my daughter also, your grandmother is watching over you. I hope she's not worried about us too much."

R: "It's so hard when a family member dies, especially not be able to go back."

Carey: "Yes, I saw her before I left for Canada because I wanted to go back home and spend some time with them. So before I left for Vancouver, in August, I went back and spent over a month there, and then I came over to Vancouver and saw mom at least four months ago before she died."

R: "That must be a comfort to you?"

Carey: "Yes. Because my brother was here for the last three years and he couldn't go back and see mom before she died."

R: "That really takes time, grieving after a parent has died."

Carey: "I still will miss her."

R: "It's very understandable."

Carey: "She was one person I could go to especially when I was pregnant."

R: "I'm wondering whether you've had a chance to grieve, with being pregnant in late pregnancy?"

Carey: "I had time to grieve over her, but because I was pregnant everyone was telling me, don't stress yourself out. I would be crying on my own and my daughter would say why are you crying like a baby?"

R: "So maybe it would be important for her to know why you're sad."

Carey: "I did tell her it's because my mom died and I miss her a lot. She finds it very funny that I keep crying."

R: "She doesn't understand."

Carey: "She still very young to understand. It's a shame because I wanted her to know about my second baby)." (Crying)

R: "It sounds as though it's a huge loss for you."

Carey: "I was pretty close to my mom. Even though we had our differences in the past it doesn't matter."

R: "There was that close bond."

Carey: "Yes. Because we were both hot tempered we would have our differences and our own opinions. She would see things differently and I would see things differently. We used to clash, but it's not something that kept us apart."

R: "You were able to work though them."

Carey: (Crying) "Yeah."

R: "I'm wondering whether you'd like me to come in tomorrow?"

Carey: "Okay."

R: "We can discuss the referral and if necessary do it together."

Carey: "Okay."

R: "And there may be other resources I can tell you about."

Carey: "Okay."

R: "And we can speak a bit more, because sometimes it helps to go for counseling, so we can see what's available and I can give you the information on that too."

Carey: "Okay."

R: "Grief takes time, to be able to cope again, to move through grief, and your loss has been so recent."

Carey: "Very bad timing. Yeah. My mom had just attended a birthday party and it was in the night that it happened, and every one at the party couldn't believe she is gone from her life forever."

R: "It's so hard, when it comes so suddenly and you don't expect it."

Carey: "Yeah. She had high blood pressure, but it was under control as she was taking medication for it, and when it happened I just couldn't believe it - then I would tell God why did you have to take her, why did you have to take my mom away?"

R: "It seems so unfair to you."

Carey: "I asked my bother to take picture of her in the coffin. As least she had a peaceful death. I must keep that in mind. She didn't suffer much. I did see her photos. She looked really peaceful. She looked beautiful. That's my consolation. I can't believe it's

my mom in the coffin. We want to bring my dad out because he's all by himself, so we can sponsor him. My brother who's been here can apply for his visa. You have to wait for one year and have a regular job and be in a certain income bracket. If he comes here that will be great. I'll need his help. I can leave my kids with him."

R: "And I think when one has a baby, there's that need to connect with your mom."

Carey: "Yeah. She always gave me advice on what to do. I have an aunt and uncle in Montreal. They keep inquiring about me and have been out to us. She's the one who sent the gift for the baby, but it needed to be a girl though." (Laughs)

R: "But they don't live here."

Carey: "No, they're in Montreal, but they keep calling and keeping in touch."

R: "It helps to know someone really cares and is there for you."

Carey: "Yes. They've been very supportive. They keep inquiring".

R: "At least you have that."

Carey: "Yeah."

R: "At the moment, and maybe your dad coming."

Carey: "Yeah. At least I have that to look forward to. It won't be soon, but it should happen."

Second interview

R: "I'm wondering whether you had a chance to look at these things (resources)?"

Carey: "Yeah I did."

R: "And the Partners in Parenting, we need the referral form faxed. You need to fill it in as well, and then I can fax it in. I've got the full details and you can check it. Is there anything specific you'd like me to put on here, anything specific you like them to know?"

Carey: "Like what?"

R: "I can say you just had your second baby, you're new to the country."

Carey: "Okay."

R: "You've been here for six months and you're keen to learn parenting, also that you've had a difficult delivery, so it would be good for you to have some support. You can have a look. That's for the social worker to fax in."

Carey: "Do you want my husband's name?"

R: "I don't think there's space for it."

Carey: "So I need to call them also?"

R: "Yes."

Carey: "That's all that need to be filled in?"

R: "Yeah"

(Baby fussing)

R: "Are you sure this is an okay time?"

Carey: "Yes that's okay, that's okay."

R: "Do you want me to pull the curtain for you?"

Carey: "That's okay. If I don't give him my milk he'll keep on crying."

R: "Yeah. And that's fine, you take your time."

R: "How's the breast feeding going?"

Carey: "It's fine, but it's too demanding and it's hurting, that's why I'm supposed to use the pump. When I go back home I'll consider using the breast hand pump to give myself some respite from this, because the doctor said she doesn't want me to stop and put him on formula. She said I should rather use the pump just once a day."

R: "Is breast feeding something you want to do?"

Carey: "Yeah. With my first child I wanted to do it full time but it didn't work out because I was working."

R: "I remember that. So do you have a pump at home?"

Carey: "It's a hand pump but I have to look out for a bottle. I left the bottle meant for the pump behind. I'll just see what can be done."

R: "Check with the lactation consultant, because sometimes they prefer a mom to have an electric pump for a little while to stimulate a really good milk supply, but I don't know.

A hand pump may be okay."

Carey: "I've used it before. It's not too bad"

R: "So at least you have everything you need for your son."

Carey: "I've got a crib coming. A play pen which I will use for now. The rest of the things I don't have but I will try to get bit by bit."

R: "What else do you need?"

Carey: "If I had a bouncer that will be helpful in case I need to move around with the child. I have bought a second hand stroller and a car seat."

R: "You have a lot of things!"

Carey: "I went round looking at community centers, at kids swap meets so I went and bought those things."

R: "You're creative. You've been able to do that. What about baby clothes, do you have any?"

Carey: "I have. The only thing I have is to start looking for some toys. When I'm busy I need toys so the baby can amuse himself."

R: "Sounds as though you're pretty good at being creative and looking in places where you can get things you need, but that it's cheaper."

Carey: "Yeah." (Laughing)

R: (Laughing)

Carey: "I saw somewhere (resource list) that you can get clothes. Can I get baby accessories there?"

R: "I don't know them personally but it's worth a call if you have the time. I have another list I can give you, but it's of places in Vancouver, which might be helpful."

Carey: "This is the car seat I bought from my friend."

Husband comes in.

R: "Is it okay if the tape for my research is on while we're talking?"

Husband: "You want to talk to me also? No problem."

R: "Are you okay with it?"

Carey: "I'm okay."

R: "Okay. I was talking to your wife about getting toys and here's the toy bank in New Westminster, and some of the places for clothes, even though in Vancouver, you can get the clothes for free. So that might be helpful for you."

Carey: "The toy bank, do I have to qualify?"

R: "You can just call."

Carey: "I can just call and go there?"

R: "Yeah."

Carey: "Things like this that I didn't have to spend a lot helps a lot because I find baby stuff very expensive out there."

R: "It is very expensive so it's a very good idea."

Husband: "Plus the tax."

R: "Would you like to take a seat?"

Husband: "No it's okay."

R: "I don't know if you want me to get you husband up to date on what we were talking about."

Carey: "Sure."

R: "We were talking about Partners in Parenting. Your wife is really interested in that program. Someone will come round once a week to talk to your wife, give information, and provide some emotional support. There is no charge at all. So you're going to call, and I'll fax the reference form through. And then I've given you the other information about resources, and I've brought more, so I hope it won't be too much for you. There are different kinds of parenting programs, all through Burnaby Life Institute. You're familiar with them? There's even one for fathers."

Carey: (Laughing) "I don't think he's going to be going with his odd working hours."

Husband: "I'm a casual worker so when I'm laid off I can go." (Laughing).

R: "I know you were really interested in learning things about being a mom and trying to be the best mom you can be. There's something else we were talking about the other day. The fact your mom had died so recently and that really takes time to be able to

grieve so that you can get through it. Just in case you're interested, there are a few places that might be helpful for you. You can call in. There is a help line, and the Family Services office, which charges according to a sliding scale. They charge according to income - you don't need to mention your savings- and at present you are working so little that if they do charge it should be the at the lowest end of the scale. There is also Reproductive Mental Health, which is on site at the hospital. If you find that it difficult, and you're crying a lot and need someone to speak to, you can get a doctor's referral to go in, and it's free. Something else to watch out for that I tell all new moms is for post partum depression. Are you aware of this?"

Carey: "Yes."

R: "It's really important for both of you, that's why I'm glad you're here now, to be aware of these symptoms. It gives you certain things to look out for. If you find that the symptoms persist for two weeks or more, it's important to speak to you doctor and get some help. There's a telephone number you can call to speak to someone – there are mom's who are available at certain times, so you can talk to someone on the phone. And if you're ever interested in the future, they also have groups. So it's available if you're feeling depressed and anxious and finding it very hard to cope. So you have a whole pile of resources, which I hope is not stressful."

Carey: "I file them and then go through it. It does have some useful things."

R: "Something else I gave you the other day is the Single Mother's Resource Guide, I give it to all moms, whether single or not. It has really good information. I am wondering if there is anything else you would like to discuss because I know you are going today."

Carey: “No, I’ll go through all this and if I find I need other information I’ll definitely call you.”

R: “Maybe I can give you a call in two or three weeks to come over and see how you found this. Would that be okay with you?”

Carey: “Yes.”

Interview with Carey at home

Carey had tried to reach researcher at work, as she had twisted her foot and had wanted to postpone the appointment. However, she had been unable to reach researcher, who had arrived for the appointment at Carey’s home as arranged.

R: “That’s why I thought it was okay. I really appreciate your seeing me.”

Carey: “That’s okay.”

R: “It’s basically just to find out how you experienced us talking together while you were in the hospital, what that was like for you.”

Carey: “It was good. At least I could open up and talk to someone about all my problems.”

R: “Yeah. I remember one thing we discussed was your very difficult birthing experience.”

Carey: “Yeah.”

R: “And I’m not sure what that was like for you to discuss it at that time?”

Carey: "Well, it was okay, because I needed to let it out actually."

R: "Yeah."

Carey: "Because it seemed unfair to me that I had to experience such a terrible delivery and I wanted to tell someone about it. And now when I talk, everything was over, and I just twisted my foot."

R: "I know. It's too bad."

Carey: "I was just getting okay, actually I was feeling much better after such a long time. It's going to be another three to four days. But I felt much better than I did. I'm putting too much stress onto it and it's starting to ache a bit."

R: "Have you been to the doctor?"

Carey: "Oh no. the doctor just told me that if it gets worse, then you come in. She doesn't want me to see her because she feels it's nothing. Yesterday was pretty bad which is why I was trying to contact you, but I didn't know what it would be like."

R: "I want to check in with you. We discussed that you and your husband are new to Canada. It's been an adjustment and things have been tight financially. We spoke about that and I'm not sure what that was like for you."

Carey: "What I told you was the truth, so I don't mind about things like that."

(Carey's husband comes in to the room.)

Husband: "Okay, I've got to move. I'm going to work. Bye bye."

Carey: "So I don't have any reservations about that. It was difficult but I think things may get better once there's some chance of permanency for him. Till now there's nothing definite, but he keeps going on."

R: "So what was it like to actually discuss these things?"

Carey: "It was good because I just had to let out whatever frustrations and insecurities I had. It's good to discuss these things. So I was comfortable with whatever I had to discuss."

R: "The other thing we discussed was your longing to be a really good mom."

Carey: "Okay."

R: "So I don't know what that was like, and then we discussed resources round that."

Carey: "Yeah, it is important and I'm trying to be a good mom to him. I'm trying to take good care of him."

R: "He's certainly looking very good."

Carey: "He's been very demanding and breastfeeding is difficult. I said I will bear it and try and feed him as long as I can because it's good for him. I really want to be a good mother to him. Only it's my temper which I showed on my daughter, and I try to cut down on that. I tend to get angry with her, I shout at her, so that's the only thing."

R: "It seems as though when you get stressed, that's where you let it out. And. I know I gave you a pile of resources"

Carey: "Yes."

R: "I don't know what that was like for you?"

Carey: "I did go through it. The one you gave me regarding clothing, I tried calling up a few places, but I didn't have any luck, so I said, let's forget about it. Yesterday I was supposed to go to a Baby and Me meeting, and I thought that I could pick up some clothes, but it was not in my luck. I had gone earlier to another program but I found it's far for me to push the stroller, so I said I will go to the one on Edmunds, and I couldn't

make it. When I thought about how to take him there in the stroller it was making me hesitate.”

R: “It was too much.”

Carey: “Yeah.”

R: “Did you check out the Partners in Parenting program?”

Carey: “She’s come. She came two weeks ago and she’s coming again on Wednesday.”

R: “What was that like?”

Carey: “Well, okay. She just briefly introduced me to whatever she had. It was mostly filling out forms. Then she brought that lady along, I’m not sure what her name is, she’s in charge of the community kitchen. She said we can join the kitchen. She told me it’s until four o’clock. I told her it’s not possible, we have to be at my daughter’s school. I said maybe once she is having her summer holidays then maybe we can go. She said they also provide childcare. I told her we’d give it a try once, then he’s bigger too, and she’s on holiday.”

R: “The last thing we spoke about in our discussion was when you told me that your mom had died.”

Carey: “Yeah, I know.”

R: “I don’t know what that was like for you to discuss.”

Carey: “It was bringing up again memories of my mom and now again it’s hard.”

R: “Yeah.”

Carey: “It’s still very fresh, but it’s good to let it out, because I still do think about her a lot. In fact, I’m worrying about my dad. He’s got very quiet ever since we lost mom. My brother’s trying to bring him over.”

R: "So is he actively doing that?"

Carey: "He did mention it to dad but I don't think he's put in the papers as yet, but we're trying to push it through. Because my brother in Calcutta is leaving so he will be alone, so we are trying to push it from this end. We are trying to make Immigration see that it's an exceptional case."

R: "Is he doing it through a lawyer?"

Carey: "Not as yet. Do you need to do that through a lawyer?"

R: "Some people do it through a lawyer when it's taking a long time."

Carey: "No, he's going to meet the local MP to speed up things."

R: "That's a good idea."

Carey: "So once my dad is here then it's not too bad."

R: "Yeah, then at least you will feel better. But at least the process is starting. Your brother is starting to think actively about it."

Carey: "Yeah."

R: "We also spoke about the fact that maybe you needed to go and see someone to discuss your feelings."

Carey: "Yeah, but so far I'm coping fine. It's okay."

R: "That sounds good."

Carey: "It's okay, it's not that I'm breaking down always. When I discuss these things it just brings up memories."

R: "Yeah, that's why I don't know what it was like for you to discuss it in the hospital?"

Carey: "It's okay."

R: "Is there anything else you wanted to tell me about your experience when you were talking to me?"

Carey: "It was nice actually to meet someone and sharing all the experiences and grievances and whatever feelings you had about the delivery. That was especially difficult and I needed someone to talk to. It was good."

R: "Is there anything else you wanted to say about it?"

Carey: "No, I'm okay. I think it was great meeting you."

